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Editorials

THE NEW TORONTO GENERAL HOSPITAL OPENED

AFTER thirty-one months of construction and twenty-six months since the official sod turning, on a site costing over $600,000, and at a total expenditure of almost three and a half million dollars, the magnificent new Toronto General Hospital was opened with great *eclat* on June 19th. We would like here to again

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heartily congratulate Chairman J. W. Flavelle and his Board of Trustees on the completion of their labors. Their task has been a herculean one, and now they deserve to be able to sit down and rest in the knowledge that they have provided Toronto with a hospital second to none in America, with 670 beds, or 300 more than the old hospital on Gerrard St. East.

The opening ceremonies were formally conducted by Lieutenant-Governor Sir John Gibson, there being present a most representative gathering of donors, physicians, clergymen and prominent citizens. The programme was not too long and was fitting to the occasion. The devotional exercises were opened by Assistant Bishop Reeves. A psalm was read by the newly elected Moderator of the Presbyterian Church. The Rev. Father Kidd spoke on behalf of St. Michael's Hospital; Mr. John Ross Robertson being unable to be present to speak on behalf of the Protestant hospitals in the city. Addresses were also delivered by Premier Sir James Whitney, His Worship the Mayor of Toronto, the Chairman of the Hospital Trust Board, Mr. J. W. Flavelle, after which Chancellor Burwash, of Victoria University, pronounced the benediction.

Several thousand people wandered through the hospital during the afternoon and evening, and viewed with interest the different buildings—Medical, Surgical, Obstetrical, Private, Emergency and Nurses'—all being delighted with every department.

Of the 670 beds, 520 are for public-ward patients' accommodation and 150 for private patients. Of the

three million four hundred and fifty thousand dollars expended on the hospital as it now stands, there has been given by the City of Toronto $610,000, including the additional $210,000 granted by a unanimous vote of the City Council on June 18th, by the University of Toronto, $600,000, and by private citizens $1,-700,000. At present there is still a sum of $550,000 to be provided, though it is expected that this will be more than made up by the sale of the old hospital buildings and site, which should bring at least a quarter of a million dollars.

The hospital will accommodate 176 nurses and 26 resident doctors with 200 employees and servants. The total number of buildings is eleven, the space covered by the site being nine acres.

The Medical and Surgical Buildings have a capacity for 450 patients. The department for the Eye, Ear, Nose and Throat 50, and Gynecology an equal number.

There are of course a good many finishing touches to be yet done to the buildings and grounds, but this work is being now rapidly completed.

Our readers will find elsewhere in this issue an article dealing in detail with this splendid structure and which will be interesting to all engaged in hospital work.

May the new Toronto General Hospital long and successfully minister to the sick in Toronto "and having done all, stand", a monument to the energy and executive ability of the men and medical men, who have thought it out, begged for it, built it, and now have opened its doors and said to the afflicted "Enter."

OPENING OF THE QUEEN MARY HOSPITAL AT WESTON

THREE Firsts! In the racing season this sounds familiar. But three firsts in the race against death is anything but familiar—it is extraordinary. Such, however, is the record of the National Sanitarium Association and its sister institution, the Toronto Free Hospital for Consumptives.

Here are the firsts: The first Free Hospital for Consumptives, the first Hospital for advanced cases of Tuberculosis, and the first Hospital for children suffering from Pulmonary Tuberculosis.

In the race against death, and in competition with the world, such surely is a proud record for these Associations. May we carry the parallel further and say that the results reflect great credit upon that able trainer, who has brought the Canadian public to the winning post for the third time, namely, Mr. W. J. Gage?

There was, on Tuesday, June 3rd, some of the usual excitement and accompaniment of the winning of a great race—the attendance of the Lieutenant-Governor of Ontario, the Prime Minister of New Brunswick, and many other gentlemen and ladies of prominence. There was the green sward, the gay crowd, the bright sun, the uniformed band, the waving of flags, the gathering of all means of locomotion, from limousines down, and last, and most important, the greeting of Royalty.



MAIN ENTRANCE. NEW TORONTO GENERAL HOSPITAL, COLLEGE STREET

The occasion was the opening of the new Hospital for Consumptive Children on the grounds of the Toronto Free Hospital for Consumptives, on the banks of the Humber, midway between Toronto and Weston. The corner stone of this institution was laid by His Royal Highness, the Duke of Connaught, in May of last year. On the afternoon of June 3rd Her Majesty, Queen Mary, having already graciously permitted the hospital to be called after her, added another most gracious act by consenting to open the hospital from Buckingham Palace, London. The actual mechanical arrangements, themselves, constituted a triumph and a marvel of the modern world of electricity. By the use of one of the wires from Buckingham Palace to the office of the Commercial Cable Company, in London, by the use of the cable, itself, from London to Canadian shores, thence by inland telegraph wire to Toronto and Weston, and by a specially strung wire three-quarters of a mile long, the hospital and Buckingham Palace were connected up, so that in a fraction of time after 6.30 p.m. when Queen Mary had touched the button in London, at 1.30 p.m. at the hospital grounds the current released a small catch, which had up till then held captive the powerful springs on the door of the hospital, and, with the ringing of a signal bell, the doors flew open and the miracle was an accomplished fact.

The sense of wonder and interest was gratified in the thought that four thousand miles of space had been annihilated by science, and was further heightened in the thought of co-operation of the Consort of

the greatest Monarch in the World, but the supreme satisfaction still remained that humanity had further excelled itself by extending strong arms to welcome and to save, not only a section of the community requiring help, but the most helpless section, those suffering from the helplessness of tender years and the added and truly terrible affliction of the dread White Plague.

Unless received and illumined with personal and sympathetic imagination, how powerless are words to convey any adequate impression of the colossal work which is now being undertaken by the institutions founded, as one speaker remarked, upon a twenty- five years' old dream of those who, at that time, were considered well-meaning, but misguided enthusiasts.

This new institution is only one part of a unit in the campaign against tuberculosis, which, for completeness of equipment, for thorough and systematic operation, it is safe to say is not equalled by any other single fighting force on this Continent, or possibly even on any other Continent of the civilized world to-day.

With a plant running well up to the half million dollar mark, caring for some four hundred unfortunate sufferers from the dread disease, with a fighting force of some fifteen skilled physicians and almost fifty nurses, together with one hundred and fifty employees of other kinds, these institutions are silently, but strongly and effectively putting up a fight against this ancient foe of mankind, a fight which is causing even the Grim Reaper, himself, to pause.

Imagine a natural park, 250 acres in extent, magnificently wooded and abounding in lake, river and forest scenery; conceive of this placed in the middle of the City of Toronto, and on it imagine a separate main building, with cottages grouped around, to care for one hundred early cases of tuberculosis (able to pay for their own maintenance). Add to this a smaller hospital for advanced cases, of the same kind. Imagine at some distance another group of main buildings, set in the midst of more pavilions and cottages, and having accommodation for patients either unable to pay at all or able to pay only in part. Conceive of yet another group of very substantial fireproof buildings and adjoining these two more substantial sections, and pavilions surrounding the whole —these occupied by patients in the advanced stages of the disease. Yet again, a separate set of handsome fireproof buildings of brick and stone, set apart for the exclusive use of 80 to 100 children suffering from this disease, and with all these one begins to have some conception of the extent of the institutions of the National Sanitarium Association, which has, for sixteen years, been leading in the crusade against consumption. Such a park, such a group of institutions, such an array of patients, such a fighting force, such an army of employees, would be the greatest of all sights in the City of Toronto and would set upon this community the seal of a progressive humanity unexcelled elsewhere in the world.

An actual view of the scope of the work is impossible to obtain in any one place. It is necessary to

review it in order to place in their proper setting the ceremonies which marked the opening of the new Queen Mary Hospital for Consumptive Children.

"Charming," "Really very beautiful," were perhaps the two most prominent voluntary exclamations that escaped the visitors who thronged the institutions at the opening, and the words were not so much praise as fact. Charming in every sense—in their magnificent location, in the beauty of the buildings themselves, in their substantial nature, and in the light and airy spaciousness of the interior, in the quality, completeness and suitability of the furnishings, the sense of fitness was gratified in every particular, so as to charm completely.

The hospital has been erected at a cost of some $60,000.00. It will provide accommodation for eighty consumptive children to start with, and may afterwards be increased indefinitely, either by the addition of wings or pavilions in the grounds.

The most eminently practical feature is undoubtedly the large and spacious Fresh-Air School, shown on the top of the centre section. To save the lives of children to the community needs no commendation, but to save and turn out healthy children, stamped with the blight of ignorance, would undoubtedly take some glory from the achievement. To look at the school-room and to consider that not only would the bodies, but the intellect and ability of these children, be saved for usefulness to themselves and to the community, immediately imparts an enthusiasm to the view and the future outlook. Such is the thought

prompted by the large airy school which caps not only the building itself, but the whole fight connected with the work.

For the rest it can only be said that in white, clean and sanitary appearance, in the rounding of the walls, thus eliminating all possible resting places for dust, and in every other particular, the hospital lacks in no particular for the wonderful purpose for which it is intended.

Nothing was more striking at the ceremony itself than the group of children, who have been accommodated temporarily in the hospital for adults, and who cheered lustily at the opening of the doors. One could well imagine that no story they had ever read or heard could have embodied the wonder of magic, and the kindness of the Fairy Queen, more than the flash which opened to them at once the doors of their beautiful home, the heart of their great Queen, and the arms of their own people in town, in city, in Province, and in Dominion.

The ground floor contains two wings, each with one ward of eight beds, one ward of six beds and one ward of two beds with necessary lavatory, bath room and toilet accommodation, as well as other service rooms necessary. On this floor also there is a reception room, a physician's office and a clinic room, as well as a large airy dining room with service rooms adjoining.

On the first floor there are two wings exactly similar to those on the ground floor, also a wing over the dining room containing single rooms for patients

requiring isolation. There are also sun rooms for children to play in and nurses' office, etc.

The second floor will be used entirely as an open air school, where school sessions will be held for a half day only (9-12), under the direction of the teacher appointed by the Board of Education of the City of Toronto.

In the basement there will be a department for the pasteurization of milk as well as a complete kitchen equipment with refrigeration plant and necessary store rooms, etc.

The building is fireproof throughout.

POINTS IN PLANNING CHILDRENS' HOSPITALS

In planning hospitals for children and babies it is well to keep a few points in mind. Segregate babies from children; separate boys from girls; make adequate provision for detention and observation; also for isolation.

Have adequate balcony space for out-of-door treatment. Have a separate door of admittance for the public. Keep the out-patient department separate from the rest of the units. Have a suitable room for the milk laboratory. A pathological laboratory in a convenient place is necessary.

The wash rooms should be ample in size, and provided with a large tank with a thermometer attached,

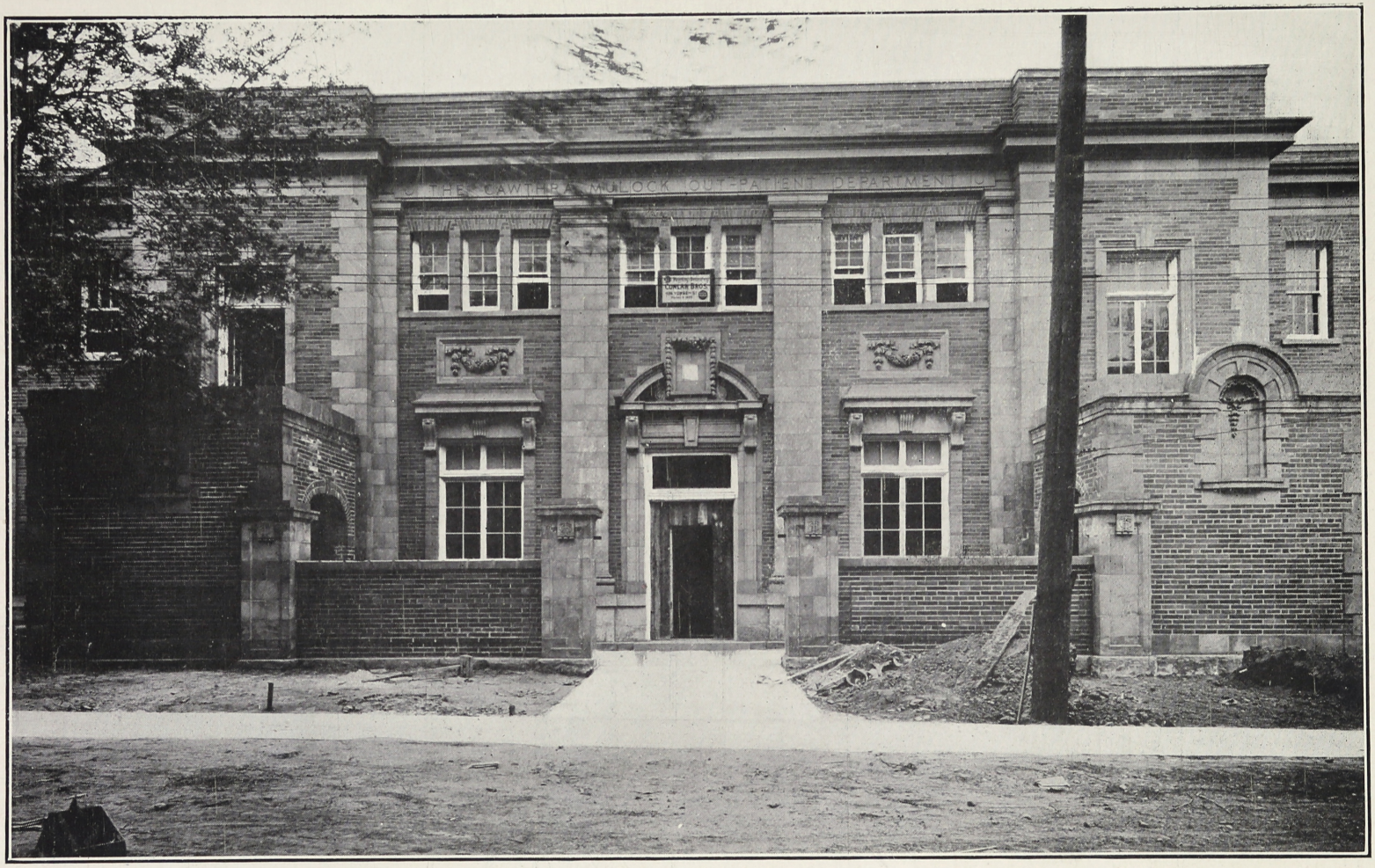
in which the warm and cold water may be mixed. The washing slab should be slightly hollowed and slant to a drain. Hopper rooms should be centrally located, and well supplied with utility necessities, such as sinks, sterilizers, cupboards, racks, shelves, gas stoves, clothes chutes, etc.

THE UPWARD TREND

At the present moment there are several hospitals nearing completion in the United States and Canada that will take rank as expressing the latest thing in hospital and medical science. The Peter Brigham Hospital of Boston, the Cincinnati City Hospital, and the Toronto General Hospital may be named as instances.

Each of these three institutions is costing between three and four million, and each is sufficiently far advanced in building to open its doors some time within the present year. The utmost labor and research have been spent in planning these great hospitals. Continental cities, the British Isles and all America have contributed their best hospital features for the upbuilding of these new and most modern institutions. Only the intimate few—those to whom have been intrusted the carrying on of the work—know how much of research, energy and time they represent.

To-day the measure of a people's humanitarianism is the standard by which it takes rank among civilized



THE CAWTHRA MULOCK OUT-PATIENT DEPARTMENT, UNIVERSITY AVE., NEW TORONTO GENERAL HOSPITAL

nations, and there is no more cheering indication of the upward trend of society than the willing, even eager desire to provide every comfort and curative agency for the sick and disabled.

Hospital construction and equipment has become a science, and these hospitals will represent the utmost that modern research and medical knowledge has expressed along this line. They stand as splendid monuments to the generous impulse and belief of the citizens as a whole, to the princely liberality of a few wealthy men, and to the unsparing and disinterested personal labor of those to whom the work has been intrusted.

AN EPOCHAL EVENT

THE opening of the Henry Phipps Psychiatric Clinic at Johns Hopkins Hospital a few weeks ago marks an epoch in the study and treatment of mental diseases. It gives final endorsement to the modern attitude toward abnormal mental conditions that these are brought about by physical causes, or by a combination of physical and mental disturbance. It proclaims that such disorder is amenable to skilled hospital treatment, and emphasizes the passing of the mad-house, the lunatic and insane asylums.

To-day psychiatry has become one of the foremost branches of medical science, and the treatment of those suffering from mental disorders has engaged the services of leaders in the medical world.

Since it is generally recognized that environment is an important part of the treatment in mental disease this new department of Johns Hopkins Hospital has been superbly equipped.

The institution has cost its generous donor, Mr. Henry Phipps, $2,000,000, and in its equipment for clinical and laboratory work along the special lines of experiment and research for which it is designed it surpasses any other institution of its kind in the world.

While the institution is intended mainly for the advancement of knowledge applicable to the treatment of mental diseases, and in this way is expected to prove of great benefit to the world at large, there will be a direct benefit to Baltimore through the provision it will make for the treatment of patients suffering from disorders of this character. There will be accommodations for about 100 patients.

Mr. Phipps, in offering to erect and equip the hospital, stipulated that in the admission of patients preference should be given to applicants from Baltimore and those cities with which his life and work have been closely associated—Pittsburgh, Philadelphia and New York.

In making terms for the admission and treatment of patients the general practice of hospitals will be followed, it is said. That is, when a case has been determined to be an acceptable one, the terms will be fixed according to the means of the patient or his family, and while there will be special accommoda-

tions for persons able to pay liberally, persons will be cared for free of charge if their condition appears to justify it.

HOSPITAL ORGANIZATION

In establishing a hospital, the incorporators first seek a Charter, or Articles of Incorporation. This gives them a name, sets forth the object of their efforts, and specifies the number of trustees.

The trustees enact by-laws, which deal with their officers, their committees, their medical organization and their administrative departments.

The superintendent and his chief officers formulate rules for the guidance of their staff.

The medical organization of hospitals varies, according to the size of the hospital, and the kind of hospital, whether it be a teaching hospital or not, and the type of disease treated.

In country towns where a half dozen or so of doctors practise, it is commonly observed that all of them are on the hospital staff.

In the cities where the hospital is municipally owned we frequently see a large number of medical men on the staff, some of whom are more politicians than scientific practitioners.

Many of the private institutions have large staffs, several physicians of equal status on the medical side, and several surgeons on the surgical side, with an intermittent service.

Neither of the above described organizations is ideal. The only ideal system is the unitary system. There should be one man at the head of each department, with sufficient assistants to do efficient work.

The resident or house staff should be competent. The more experienced the better. A few of the larger hospitals adopt the resident system, each main department having a resident, i.e., a man who has, say, served two years as an interne.

The larger hospitals have not yet come to recognize the value of the resident system, nor have the internes come to appreciate the value of extending their time of service in residence.

A resident system is good for the visiting physician, and good for the patients.

WORK FOR THE CARNEGIE FOUNDATION

Now that Mr. Flexner has done so much for medical education by the publication of Bulletins Nos. 4 and No. 6, what a boon it would be if Mr. Carnegie's attention could now be drawn to an investigation of American Hospitals and Schools of Nursing. Here is a field for study. The work of the medical staff might well be looked into first. Is their service continuous or rotatory? Do they attend daily at a regular hour? How long do they remain at the hospital? How is the out-patient department served? Is the examination of patients careful and complete, or casual and hasty? Do the attending physicians allot

problems in the study of disease to their assistants, or do they monopolize all the cases themselves, and when ready to relinquish their service have no one trained to carry on the work efficiently? In how many hospitals do the men retire graciously and spontaneously when their natural powers show sign of abatement? In how many do they hang on until they are dropped?

Should the medical staff give their services free to hospitals? To what extent are residents and internes paid for services, and what do the hospitals give them in opportunity?

Is the business end of the hospital properly administered? Are the proper employés chosen—the right man for the right post? Does he give an efficient service? Is he properly fed and housed, and what provision is made for his old age, when his services for the institution terminate?

Are the nurses competent? Are they properly taught? Are they overworked? Are they overtrained, or under-trained? Are their hours too long? Are their medical instructors always prompt and regular at classes, whether on salary or not?

Is the building suitable for a hospital? Is it fireproof? If not, what provision is made for fire escapes and for fire drill? Are the service rooms commodious and convenient for nurses and for patients? Are there adequate laboratory facilities? What provision is made for the teaching of students and for their general accommodation?

These are only a few of the hundreds of questions the Carnegie representative well might ask. The mere publication of the replies, without comment, would make many hospital authorities, staff doctors and trustees blush, close up a lot of death traps and lead to the improvement of hundreds of institutions.

GRADED NURSES

JUST as there are various grades of schools from the kindergarten to the university, so will there be various grades of nursing schools.

While one must admire the work done by those favored institutions where all the pupils are cultivated women, graduates of high schools, given a leisurely training of three years, working eight hours daily, and initiated into the mysteries of bacteriology and many of the medical branches, it is manifestly impossible for all schools to accept only such a class of student, and to give such an extensive training.

First, there are not enough high school applicants to fill one training school in a hundred. Second, the majority of hospitals cannot afford to give an elaborate course for three years. Third, the sick people have not one-tenth enough nurses of average quality to look after them.

So that we must necessarily have training schools of varied degrees of efficiency, some of which turn out nurses not properly trained. Naturally, if the training varies, as it must, we must have varied

grades of nurses; and, because of this, it would be well to have classifications—two or, perhaps, three grades.

The American Hospital Association at its last meeting appointed a committee to report on the classification and grading of nurses, and we shall await the publication of their report with much interest.

AMERICAN HOSPITAL ASSOCIATION

Upon earnest request we again call attention to the annual gathering of the American Hospital Association which meets in Boston on August 26-29 inclusive.

The executive committee has been most active in preparing for the meeting, and the various sub-committees are equally energetic. The committee on out-patient work is making especial effort to prepare a comprehensive report. The committee on nursing has its report already in shape. The membership committee reports at the present moment of writing (May) over one hundred and fifty new members this year. If each old member feels under obligation to assist this committee by bringing in at least one new member, a large accession to the membership will accrue before the convention opens.

Mr. Conrad Thies, Honorary Secretary of the British Hospitals Association, has promised a paper on British and German Hospitals. A whole day will be devoted to the discussion of problems relating to small hospitals.



INTERIOR SURGICAL WARD "TIMOTHY EATON MEMORIAL," NEW TORONTO GENERAL HOSPITAL

The Boston people will give a hospitable welcome to the association.

It is to be hoped some action will be taken at the coming meeting looking toward the holding of a World's Hospital Congress in the near future. The American Hospital Association should take the initial step.

Trustees and superintendents are eligible for active membership in this association. Assistant superintendents and members of hospital and charitable associations may become associate members. Copies of transactions of the association are sent to every member yearly, and these form most valuable reference books.

Readers of the HOSPITAL WORLD who would like to procure copies of the earlier transactions should apply to the Secretary, Dr. John N. E. Brown, of the Detroit General Hospital, who will forward any one number on receipt of fifteen cents to cover postage.

HE KNEW

IT is often amusing to hear hospital patients relate their experiences or give out the hospital knowledge their wonderful eyes have gathered.

In the surgical ward of a hospital one day one patient was heard to say:

"The worse we are the better they like us here. Why, they won't think nothing at all of that cut of

yours—they'll laugh at you. But wait till you get a great big lump inside your head like me. Then they'll make something like a fuss over you—you couldn't hardly get more attention if you was a king. Little things like your cut, the boy doctor sees to, but when you get in my shape the chief looks after you every time. My, yes!"

Original Contributions

COMPARISON BETWEEN GERMAN AND AMERICAN CONSTRUCTION

BY DR. JOHN N. E. BROWN,
Superintendent of Detroit General Hospital, and Secretary American Hospital Association.

In Germany a general hospital is properly so called, all sorts of patients are received—acute mental cases, tuberculosis, and the ordinary contagious diseases, in addition to the usual medical, surgical and other cases; provision is also made for epidemics of cholera and plague. This permits medical students, resident medical officers, and nurses to procure an all-around training. We know of no such hospital in this country.

The hospitals of Germany are constructed by the state or municipality. The amount of money needed is asked for and can be counted on. In America we are mainly dependent as yet on the voluntary system of support; though a few of our large cities are undertaking the building of hospitals as a proper part of civic work, making appropriations in their annual budget for this public service, just as they do for their water-works, street cleaning, etc. In America, hospitals start in a small way, and are added to, so that some of our older and larger institutions present a conglomeration of buildings such as are seldom found in Germany. The German hospitals are planned by the municipality or the state architect, an official of much dignity. The office is the goal after a long and rigorous experience of technical training. This official also plans the city hall, the court-house, the schools, and other publicly-owned buildings.

Before beginning to build a German hospital, careful inquiry is made by the authorities as to what number of patients they will provide for; what amount of room will be required for males and females respectively; what space will be given over to medical, surgical, and other sorts of cases; what space for kitchen, how much for laundry and other services. A study is made of institutions already built, and statistics relating to all services carefully studied. The building must conform to certain govern-

mental regulations, such as the space allowed for day rooms for convalescent patients, the construction of stairways, etc.

Architects and medical men in Germany have not the freedom they have in America to carry out novel ideas. A close observer will find fewer mistakes and fewer oversights than he discovers here. This may be explained by the fact that the Germans follow precedent more, and the architect and director have had advantages both in the matter of training and extensive observation which few American architects and directors seem to have enjoyed. It is more customary in Germany than in America for architects to construct a model of the hospital they propose to

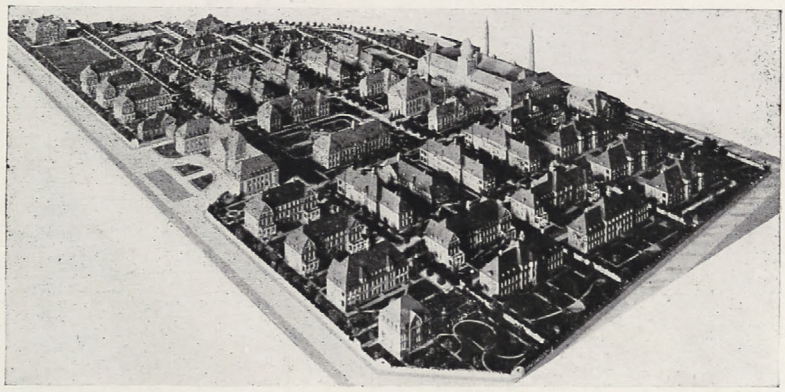


FIG 1.

erect. The advantages of doing this are many; we can strongly commend this custom.

German hospitals are usually built on extensive grounds, those of the pavilion type covering sometimes eighty or ninety acres. These grounds are beautifully parked; trees and gardens surround the pavilions. There is a fine sense of space all about. The air is clean and fresh, and sunshine floods the whole place. The buildings are remote from the dust and din of traffic. Convalescent patients are seen on the lawns, sunning themselves or resting beneath the shade of the low trees. Throughout the largest hospital sites run driveways or walks which divide the grounds into rectangular blocks. On each of these blocks stand groups which correspond to a general classification of patients. One does not

find as many balconies or roof gardens as in America. The patients are taken out on the terraces and lawns.

The ward buildings are not high, chiefly one and two storeys. The architectural effect, both of the groups and of the individual building, in this natural setting, gives a sense of pleasure to the visitor, and must be attractive to the patients.

In many instances the visitor arrives first at a lodge—a picturesque little structure, the residence of the *Pförtner*, or at his office off the main carriage entrance which runs through the administration building. This official receives him, learns his



FIG. 2.

business, and directs him what to do and where to go. Frequently the *Pförtner* is detailed to accompany the visitor throughout the institution.

The newer hospitals are of the most thorough masonry construction. The general finish of the exterior is cement on common brickwork, applied in many simple and charming forms. Much well-designed brickwork is also seen. The roofs of red tile tone pleasantly with the green foliage.

Ward floors are generally of tile or terrazzo. There has been some effort to obtain a more comfortable floor through the use of battleship linoleum. As in America, the use of linoleum and of plastic monolithic flooring seems to be still in the experimental stage.



FIG. 3.

Windows are usually of the casement type, some having transoms at the top. One type has a double transom, which, upon being operated, opens the outer sash at the bottom and the inner one at the top. There is now coming into favor in England and America a type of window with several cross-sashes pivoted at the bottom similar to a transom. Either style of window gives practically quite sufficient natural window ventilation. The latter type has the advantage of directing the air currents upward; the former are more quickly and more easily manipulated. The German windows generally extend close to the ceil-

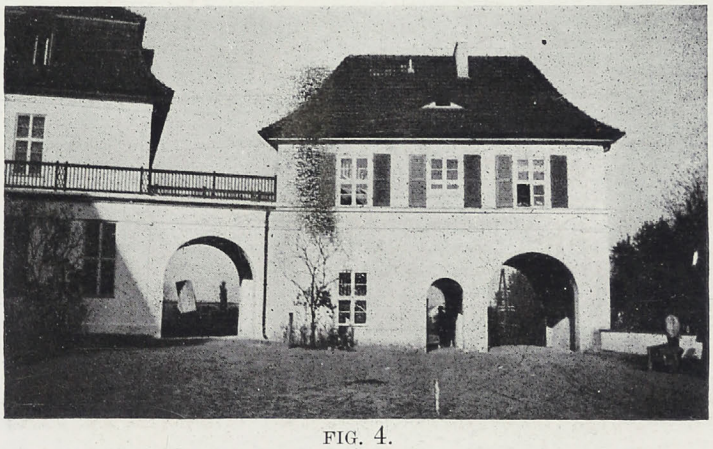


FIG. 4.

ing; and the sills are low enough to give the patients a view out of doors. We seldom see casement windows in the hospitals of this country.

The accessory rooms of the ward are grouped separately at opposite ends of the ward. This arrangement, we consider, makes for the convenience of the nurses. In America we seek to give two sides and one end of the ward to the air and sun.

The Germans make fine provision for natural treatment of patients on the medical side by providing, in their bathhouse baths of all sorts—mud, sand, carbonic acid, steam, electric, hot and cold water, in various forms. The private sanitariums provide special baths, such as sun baths and open-air baths. This bathhouse of the hospital is generally placed near the medical

group of pavilions, and is related to this group much as the operation house is to the surgical group.

It is common there to see mechano-therapy rooms—Zander rooms. These are very rarely found in America The various



FIG. 5.

apparatus in this department are found most valuable in the treatment of deformities, contractures, and similar afflictions.

The operation house contains all the operation rooms with their annexes. These subsidiary rooms are fewer in number

than one sees in some of the newer American hospitals. The surgeons' washup bowls are often found in the operation room proper. There does not seem to be the same accommodation for operating-room nurses as is provided on this side of the water. Nurses there, however, are apparently not so numerous in attendance at operations as they are with us. Provision for sterilization is most complete, and in the room provided for this purpose you will often see apparatus for distilling water and supplying salt solution.

At the St. Georg, Hamburg, the air is filtered through gravel and sand before being forced, on the plenum plan, into the

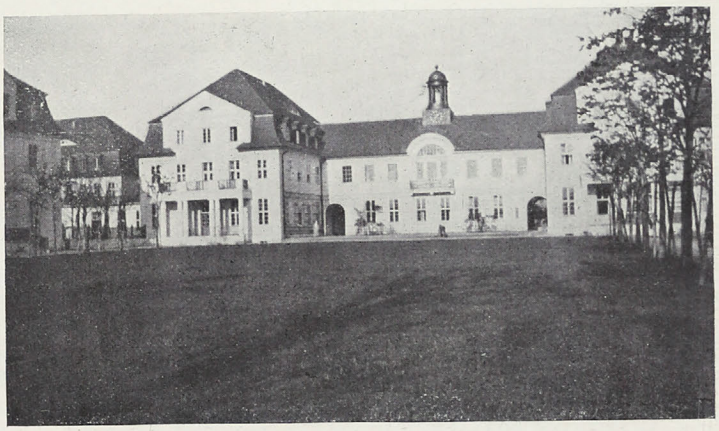


FIG. 6.

operating-room. Following each operation, the room is disinfected by steam. We have not noted such complete precautions anywhere in the United States.

In this country we are beginning to manufacture for our operating plants copious supplies of sterile water for surgeons' and nurses' washup; for example, the Gary Hospital, Gary, Ind.; St. Luke's, Presbyterian, and the Augustana Hospitals, Chicago; the German, Philadelphia; the German Deaconess, Buffalo, and the Harper, Detroit.

The Germans seem to agree with our latest conclusions in regard to simplicity in the matter of ventilation and heating. We have not heard of such failures of mechanical ventilation in

hospitals over there as we have in some of the leading hospitals in America where the plenum system seems to have proved a failure. The only place in which we saw this system working efficiently was at the Victoria Hospital, Belfast, Ireland; even there in the nurses' residence it was discarded. But on duty, nurses, like patients, submit to it,—an even temperature of about sixty-six degrees with all windows and doors tightly closed.

The Virchow, in Berlin, is ventilated in the following manner:

In the underground floor of each of the pavilions are placed one or more ventilating fans, according to the requirements.

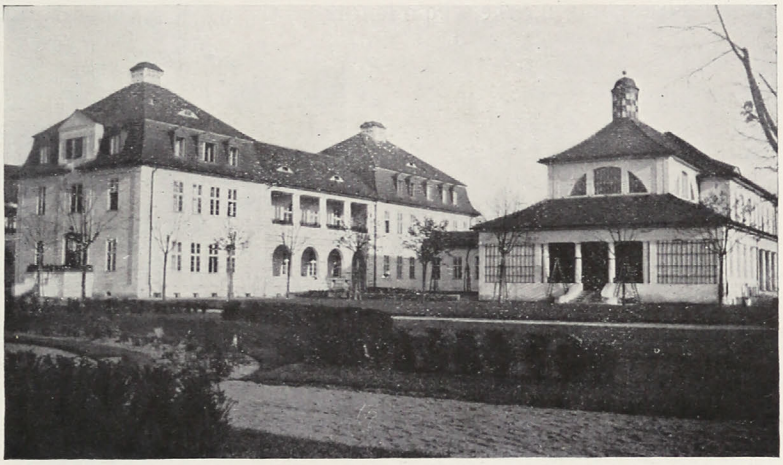


FIG. 7.

These draw in fresh air from vertical little air houses standing amid the shrubbery a few yards from the pavilions. The air passes through a chamber for straining out the dust, a cotton wool filter being used. The air is then driven into a steam-heated chamber, and from here through distributing channels, and hence through wall channels into the different rooms. As the local climate is sufficiently humid, the air is not moistened, as is done in some places. The foul air is withdrawn from each room by sufficient outlet channels, which extend to the roof story and terminate in a chamber in front of an exhaust fan. It is sucked from here and driven through ridge turrets into the open. In

addition to this mechanical system, provision is made for natural ventilation through trap windows. The ventilating apparatus of the lavatories, kitchens, and sink rooms is made particularly effective in order to quickly carry off the vapors and mal-odors which form there.

Germans have their heating and power plant placed in a service building, which building usually contains the kitchen, laundry, and employees' dormitories. The medium of heating is by means of steam or hot water. The pipes may terminate in radiators located along the centre line of the room or along the walls. In the wards of the Virchow there are two four-inch hot water pipes running the whole length of the ward. These can be



FIG. 8.

more easily cleaned than the ordinary radiators, and can be inspected very readily. A sensible type of radiator is the one now being put in the new measles building of the Willard Parker Hospital, New York City, there being room between the sections to allow for easy cleaning.

German laundries and kitchens are spacious. One seldom finds hoods over ranges and mangles. The black, dirty-looking stockpots of the American hospital kitchen are nowhere in evidence in Germany. Stockpots are covered with nickel, enamel, or white metal, and set on a neat, round, central foot. Some of the pots are provided with a water jacket as well as with a steam

jacket, which permits their being used for a variety of purposes. Both kitchens and laundries are divided into separate rooms for the separate duties; sometimes these subsidiary rooms are merely alcoved off. In America we more often find nearly everything done, both in laundry and kitchen, in one large room.

The Germans provide in their hospitals more laboratory accommodation than we do. This is especially true of their teaching hospitals. In one of the medical or surgical units of the Charity Hospital, Berlin, for instance, you will find commodious laboratories adjoining the ward unit—for bacteriology, for chemical pathology, for surgical pathology, for X-ray work, etc., and

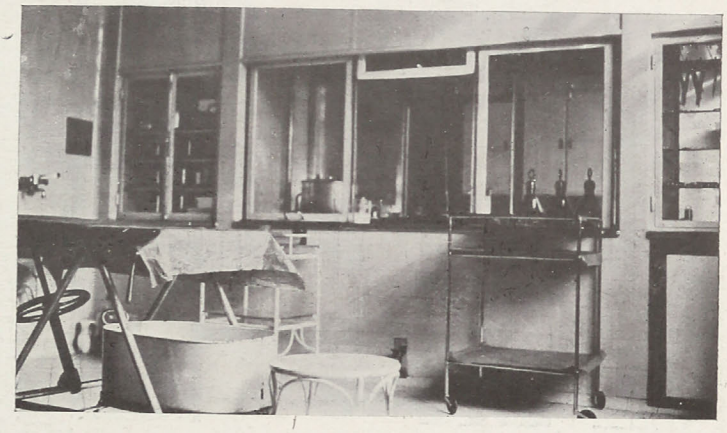


FIG. 9.

other special rooms for original research. Our laboratories are remote from our wards, which probably corresponds to the scientific status of our medical organization. Our clinicians are not pathologists; many of them have arrived at the kingdom of clinical medicine after a prolonged period in the realm of pathology, hence can combine the work of the two in one in a great measure.

Disinfection receives much more attention in Germany than in America. Disinfection houses are seen in connection with all large German institutions. In America the writer has not seen any. In a typical German disinfection house, belonging to a

large hospital, you will see provision made for disinfecting various types of material in various sized sterilizers. These sterilizers are set through a wall—the soiled or infected material being brought to the room on the "unclean side," placed in the sterilizers, and withdrawn in a room on the clean side. Off this clean room may be found the store room for the disinfected clothing. Provision is also made for the disinfection of doctors, nurses, patients and employees. There is a room for the removal of infected clothing; adjoining this is the bath room, and beyond a clean room in which fresh clothing is put on.

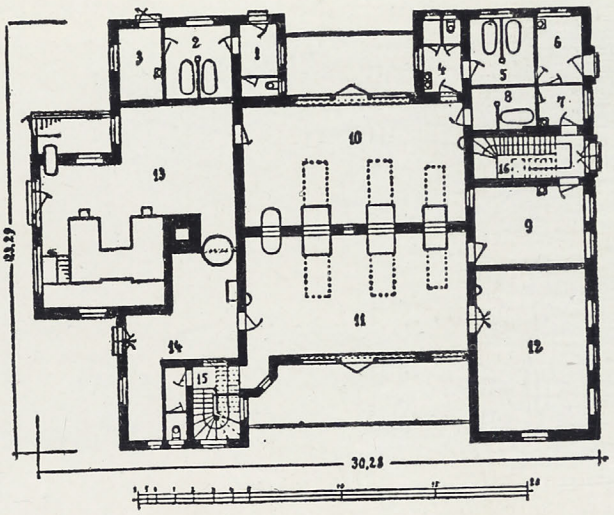


FIG. 10.

Besides the complete disinfection plant in the disinfection building, in many hospitals provision is made in the ward unit for the disinfection of ward linen. A vessel is placed in a wall between two rooms, one-half of it projects into the room for the reception of the soiled linen, the other into a small room on the other side of the wall—the clean side. After the linen is first thoroughly soaked and the blood and pus stains removed, it is carefully disinfected by means of heat carefully applied, plus, in some instances, the use of an antiseptic solution.

Sewage from wards is piped to a cement cavehouse—the sielgrubenhaus—and here disinfected before being allowed to run off into the general sewage system of the city. This feature is absent in America, but should be introduced. Many hospitals here allow their typhoid stools to pass into the general sewage system, not disinfected, or only partially disinfected. And many cities secure their drinking water from the lake into which this sewage is poured!

Basements are used in German hospitals for the protection and carrying of piping required for the heating, ventilation, and other apparatus, and for storage. In America, too often, basements are used for laundry, kitchen service, or even as dormitories.

For the illustrations accompanying this article the writer is indebted to Mr. W. B. Stratton, architect of the Detroit General Hospital.

THE NEW TORONTO GENERAL HOSPITAL

When the doors of the new Toronto General Hospital were thrown open on June 19th, the institution might be fairly termed one of the most modern and complete hospitals in the world. The citizens of Toronto for whom this magnificent new hospital has been erected thronged through the silent corridors and the spacious airy wards. They saw in part at least, for to see all would require much longer time than one visit allows—the result in total summary to date of the progress of science in caring for the sick.

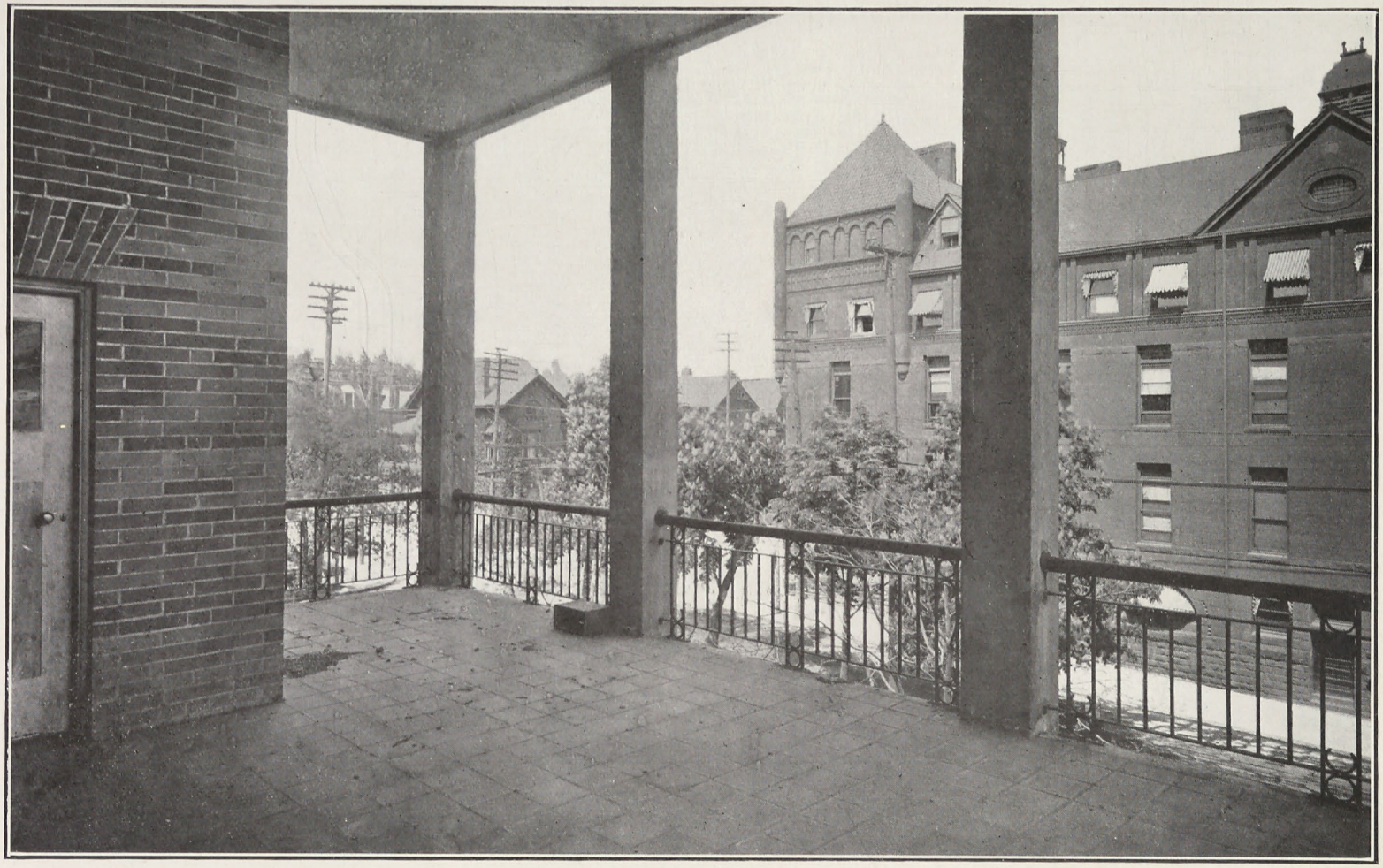
Toronto has now a hospital second to none. Visitors, who so far have not been through, have a surprise awaiting them.

Like the building of a battleship, the building and equipment of a modern hospital is based upon the accumulated knowledge and preceding experience of the world at large. Toronto's General Hospital is the newest hospital on the continent at the present time, and probably the newest hospital of first-class importance in the world.

It embodies all the improvements, all the successful ideas, all the innovations common to the most modern hospitals in Europe or America, together with the new ideas that have been born since these other institutions were established. Many of these innovations, these devices for rendering patients safe or more comfortable, for making their treatment more surely successful, or for insuring the sanitary precautions which make a well-conducted modern hospital more wholesome and free of germ-infection and disease contagion than the average home, were worked out from ideas resulting from local enthusiasm.

The trustees and officers, the architects, the expert hospital specialists brought to Canada for the purpose, the staff physicians and surgeons and the contractors have one and all been eager to give to the new Toronto General Hospital all that their practical co-operation, their technical experience, and their expert advice could afford.

With the determination that this new hospital for Toronto should have no superiors anywhere, the trustees, in some cases, personally visited, in company of the architects and the superintendent of the hospital, famous institutions in the United



NURSES' WING. NEW TORONTO GENERAL HOSPITAL

States to observe and compare. Information bearing upon some of the greatest hospitals in Europe, together with their plans, were also secured and carefully studied. What was worthy of incorporation after comparison and detailed consideration has been adopted. Proved superiority, as recognized in the medical profession, or after actual comparison, has determined in each case what system, what construction, what apparatus, what arrangement, what materials, what finish, what choice of details throughout this immense organization, should help to make the new Toronto General Hospital, in hospital efficiency and coordination, the last word to date.

Visitors to France will have their attention called perhaps to the famous Hotel Dieu, as the greatest public hospital in France is called. They will on visiting that great institution see many things of interest, but nothing of greater novelty or efficiency than in the new hospital at the corner of University Avenue and College Street.

Visitors to Berlin may inspect the Virchow Hospital. But it was built 15 years ago, and science has kept moving. Guy's Hospital in London is famous, but the famous hospitals are apt to be old ones. Toronto's hospital is new, modern, absolutely. St. Bartholomew's in London has long been a standard and a model, but newer ideas are evolving in this age of progress, and more especially on this new continent of America.

In the United States are many fine hospitals, but only one newer, and therefore possibly as complete, and as advanced as the new Toronto General. This is the new Cincinnati Hospital now in course of construction. It is to hold 600 patients. The Toronto hospital will have room for 670. The Hebrew hospital, Mount Sinai, New York City, is noted for its thoroughness and the completeness of its equipment, but it, too, is older. The Rockefeller Hospital is small. The Bellevue, perhaps one of the leading hospitals of New York City, is large, but it lacks many of the advantages of the new Toronto General. The Roosevelt of New York is old and small by comparison. Detroit has several fine hospitals, Cleveland has, but representatives of the fine American hospitals will now come to Toronto to see the latest development in hospital construction and equipment.

Of Canadian hospitals the Toronto General stands unique.

The Royal Victoria, of Montreal, is a famous Canadian hospital, but it holds much fewer patients compared with the Toronto General Hospital. The Montreal General Hospital will take 400, about the same number as the old Toronto General on Gerrard Street.

A tour of the new hospital begins with the Administration Building. The visitor enters by the front door through the College Street gate and courtyard. It is a beautiful entrance and approach from the architectural standpoint. Once within the administration building the counter of the information bureau immediately presents itself just in front of the doorway to the right. Here visitors are to be told about the hospital or its patients, or make enquiries for any member of the staff. To the left is the office of the secretary. The Administration Building also accommodates the 26 resident physicians, who have private rooms on the top floor.

By turning to the right after passing through the various business offices connected with the administration, the visitor can pass from one building to another, the spaces between being connected by corridors, ante-rooms, and arcades. Each building is distinctly by itself, however, thus segregating the different departments and eliminating even the minimum possibility of cross contagion that remains after the expert battle against germs has been waged in the wards and sterilizing rooms.

The next building on the tour houses the Medical Department. Most people think of medicine as practically the entire weapon of the hospital and its doctors against the enemies that afflict the health of humanity, but diseases relying upon medicine form only one class of the many cases requiring hospital treatment. The Medical Building is very complete, and cases will be cared for according to the latest advice that science has given. To ensure cleanliness even the mattresses on the patients' beds are subjected to live steam. There is a room with a big iron box into which about a dozen mattresses at a time are placed on racks. Then the door is shut and the steam turned on.

Another point the visitor will be quick to notice in walking through the big, airy wards and spacious corridors, and that is the way the walls, the ceilings, and the floors have been finished so as to be kept easily and perfectly clean. Everything is abso-

lutely smooth and hard. No cracks or roughness anywhere. No place where dust or germs could collect or lodge. No place where water or dampness could soak in. The floors are covered with a beautiful dull red kind of noiseless linoleum as used on the decks of the battleships in the German navy.

Toronto citizens will have to adjust themselves to a new scale of ideas when talking about the new hospital. They may be pardoned for a considerable degree of civic pride in Toronto General Hospital as it now stands. Other hospitals in larger cities may in some cases be equipped to care for larger numbers, but none are able to devote that specialized attention to every case, from the simplest to the most difficult, that will now be in the power of Toronto General. And few hospitals will have such pleasant, comfortable, homelike wards, sun-rooms, balconies, verandahs, and roof gardens, lawns, and shrubberies. The grounds of the Toronto Hospital will be a feature in themselves, with their old trees and their thousands of flowering shrubs—these last, by the way, donated by prominent nurserymen—and their flower beds. To think that this section was one of the overcrowded districts of the "Ward" at one time and to look at the stately buildings and spacious gardens now is to realize what a wonderful transformation has been accomplished in the space of a couple of hard-worked years. That such an institution could be provided at the very heart of a busy city is the marvel of visitors from other places. Were it not for very special circumstances in the case of Toronto, even this city could not expect to be so fortunate. The site occupies the whole block from Elizabeth Street to University Avenue, from College Street to Christopher, an area of 9 acres.

This hospital, it must be remembered, has been built for the use of all the citizens of Toronto, not for any special class. From richest to poorest, everybody in need of hospital treatment may be treated here. No better treatment could be obtained by going abroad so far as facilities and apparatus go. No citizen of Toronto needs to be sick and remain uncared for while this great refuge holds open its doors. Those who can pay are supposed to do so as their means permit. Those who, in the struggle to merely live, cannot spare the money to cope with sickness in the family, will find a helping hand worthy of the name in Toronto's new "Hotel Dieu."

It was originally estimated that $1,850,000 would cover the cost of a 400-bed hospital, furnished and equipped. This sum included the cost of the smaller site first purchased. With the site double that at first intended, the bed capacity and equipment increased by 67½ per cent, and a complete Emergency Hospital added, the total cost of the enterprise will be $3,450,000. The increased cost is due to the increase in the size of the site and capacity of the buildings, and to the very considerable increase in wages and cost of material since the original estimate was made in 1904, over eight years ago.

Sir William Osler visited the property and buildings during the last two months, and stated he considered the whole arrangement of the hospital as perfect as could be. Eminent hospital authorities who have been in Toronto during the last six months, and who have inspected the buildings, have also expressed admiration for the accommodation and the equipment.

Of the 670 beds, 150 only are for private and semi-private patients. As the Private Patients' Building is a self-contained unit, all the remaining buildings, with grounds and gardens, are for the use and benefit of the sick poor.

The development of this enterprise has been made possible through the co-operation of the Government, the city, and the citizens at large. The building containing the surgical wards of the hospital is being erected by Mr. J. C. Eaton, who is also providing the equipment for the surgical theatres. The cost of the Out-Patients' Building is borne by Mr. Cawthra Mulock. The Emergency Building, with complete equipment, including ambulance service, is the gift of two ladies now deceased, the Misses Shields.

Patients to the new Toronto General Hospital will be introduced to its kindly offices by way of the ambulance entrance and admitting department on University Avenue. If the case be one following an accident, the emergency department—a fully equipped hospital in itself—is just to the left at the reception lobby and connected to it. If the patient be ill with symptoms which leave doubt in the physicians' mind whether a disease involving contagion is presented, the patient is provided with quarters in quarantine until the development of the disease makes its pronouncement certain.

This department of the Toronto General Hospital is the outcome of a suggestion made fifteen years ago to two sisters who wished to build a perpetual memorial to a loved brother. They asked the family physician to think out a way in which their joint fortunes could best be used. Their ideas underlie all that has been done to carry out the plan which they adopted. First the memorial, next the providing of every modern facility for the bringing in and taking care of those injured or taken suddenly ill, and lastly the teaching of the students of a great university the practical aspect of what has been aptly called urgent surgery. To this end there has been designed and built a hospital with two large accident rooms and etherization room, a large and well equipped operating room, a sterilizing room, supply room, etc., on the ground floor.

The second floor, in addition to wards and service departments, has a large clinic room designed and being equipped for the teaching of advanced surgical technique.

In the basement a dark room with outfit for stereophotography is being installed.

There are four public wards with three beds each, three semi-private with two beds each, and three private wards. The corridors, wards and other parts of the building are admirably balanced for the most efficient service. In the large operating room a Bartlett light has been installed—the first we believe in Canada. From a circle 8 ft. in diameter, 8 lights are focused and reflected upon the field of operation in such manner as to make it impossible to get a shadow anywhere. An observation stand will make it possible for visitors to follow closely the steps of an operation. Attached to hospital is a garage for three motor ambulances, one of which, embodying every desirable feature, is ready for use. Ambulances will enter a domed court from University Ave. and will be shut off from observation as patients are removed to the hospital. It is proposed to send a house surgeon out in response to all calls upon this service.

The operating room staff of every hospital in Toronto has been taxed to the limit in the past by rush operations coming in during a full day's work. With this new department available and ready 24 hours a day and open to all who have won recog-

nition in the doing of major surgery the pressure should be relieved.

Miss Hanna, who has had experience in the Hamilton City, McLinae and Johns Hopkins Hospitals, is the nurse in charge, and has entered upon her duties with the very highest endorsation.

If there exists anywhere else a department such as this and as perfectly designed and equipped for its special purpose the fact has escaped the knowledge of the writer of this notice.

From the bequests left by Agnes and Jane Shields there will, fortunately, be available for maintaining the service of this hospital at its highest efficiency a sum much in excess of the total cost of the building and its equipment.

The main kitchen of the hospital is in the angle of the surgical wing. Here are situated the battery of four coal ranges, the charcoal broiler, the dry steam ovens, the steam kettles and soap boilers, the gas ranges, the steam dish washing cabinet, and the other paraphernalia of an up-to-date hotel kitchen, with the difference that it is larger than any average hotel, and has more work to do.

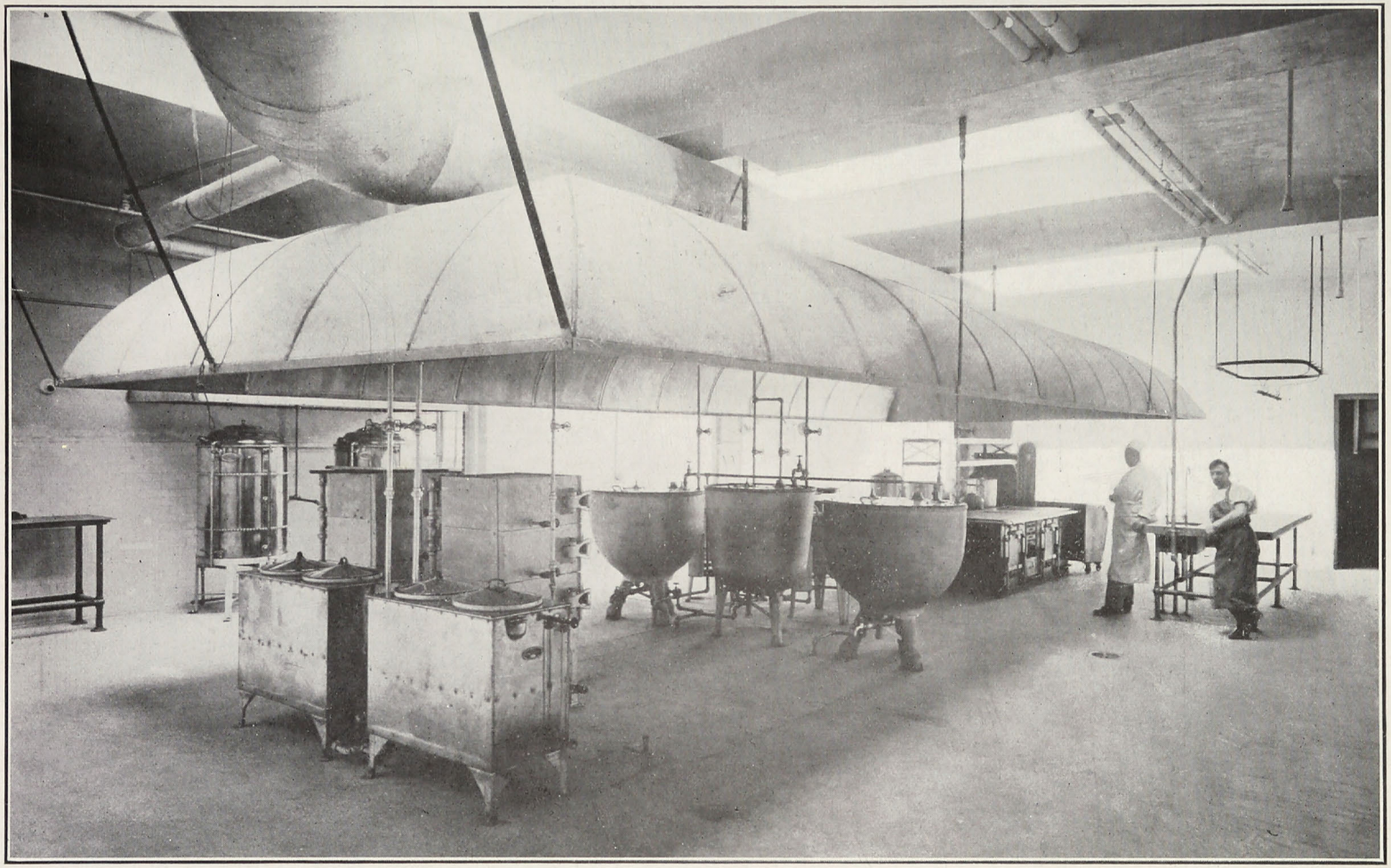
Five hundred horses add their motive energy to that of the nurses and doctors. Here is made the steam which operates the dynamos to generate electricity for light, power and medicine, the hot water to heat the buildings, the fans to filter the air through the water curtain; an ice-freezing plant, a water distillery, a laundry, and a complete range of workshops are situated next the power house at the corner of Christopher and Elizabeth Streets.

The Pathological Building shelters one of the most important departments of the whole hospital. A larger sum of money will be expended here every year in experimental work, without which, medical science, like any other science, would be at a standstill. Research work has been provided for in the Toronto General Hospital by an endowment fund in connection with Toronto University. Experimental work, both in medicine and in physiology, is undertaken.

The Private Patients' Building will cost $350,000, or about one-tenth of the total expenditure. It will not only be self-supporting, but will provide a surplus revenue to apply towards the maintenance of poor patients.

Close by the power house on Christopher Street is situated the laundry, a modern plant, operated by steam and electricity, utilizing the very latest improved machinery. An automatic elevator, which is worked entirely by push buttons, even to the closing of the cage doors, takes the visitors up from the street level. Women in white aprons are busy with electric irons. Great revolving tumblers are drying the clothes. Other revolving churnlike casks are half-filled with soap and water, into which live steam is turned. The machines and irons in the laundry are all operated by separate motors in the approved modern manner, thus doing away with shafts and belting. The hospital laundry has a capacity for 5,000 pieces per week.

One hundred and seventy-six nurses will be accommodated in the beautifully equipped Nurses' Home. Across the Tennis Courts the Obstetrical Department Building is built. The two are connected by the covered passageway shown at the back of the lawn, as also to the Surgical Wing.



KITCHEN, NEW TORONTO GENERAL HOSPITAL

Society Proceedings

AMERICAN HOSPITAL ASSOCIATION—DETROIT MEETING

(*Conclusion.*)

QUESTION DRAWER.

PRESIDENT: These questions we expected to be presented by Dr. Seabrooke. Dr. Seabrooke has just written the secretary that she started for Detroit, but has a very severe illness, so we have concluded to ask Miss Anderson kindly to present the questions.

MISS ANDERSON: I am sorry that Dr. Seabrooke was obliged to drop out, because she probably would have had these questions well assorted and had an idea who could best answer them. I hope we may have a number of terse, short replies, rather than one long dissertation, perhaps, on a question.

QUESTION NO. 1.—*Should a general hospital admit venereal patients?*

MISS ANDERSON: One other question I thought might be taken up at the same time:

"How should a general hospital stand with reference to tuberculosis?"

The person answering the first question I thought might answer the other. Dr. Babcock, will you start the discussion?

DR. BABCOCK: I do not feel especially competent to answer that. Our practice is not to admit cases of delirium tremens. We do admit cases suffering from typhoid fever and other acute diseases, suffering from delirium at times, and I believe it is the duty of all general hospitals to admit those cases. As to tubercular cases, most cities and towns of any size are providing hospitals especially for the treatment of those diseases, and I believe, if the time has not already arrived, it will soon come when the general hospitals can consistently refuse to admit tubercular patients, and I think we shall all be glad when that time comes.

In the past, before the construction of institutions in this city for tubercular cases, we have admitted incipient cases of tuberculosis. It is not necessary at the present time. Patients that

have been discovered in the hospital by laboratory examination are generally transferred by arrangement with these institutions.

Miss Anderson: I think Dr. Babcock misunderstood the first question, "Should a general hospital admit venereal diseases?"

Dr. Babcock: Yes, I think a general hospital should take venereal diseases. It should make provision for the treatment of those cases if possible by themselves.

President: I should say that would depend on circumstances. Where the salvarsan is to be used, unquestionably the patient should be taken into the hospital and stay there long enough to have the administration of the remedy safe and efficient. There are many individuals possibly that can be treated in the out-patient department. If I were asked to tell my opinion, I would say that some cases of venereal diseases should be admitted to the hospital, not all.

Miss McCalmont: I should like to put that question: Should a hospital admit venereal disease without informing the nurse of the nature of the case?

Miss Anderson: I think the answer to that is self-evident. They certainly ought to inform them.

Miss Aikens: I was at Toronto last year at the Canadian Association meeting, where they had a very animated discussion about the relation of the general hospital to tuberculosis patients, and I should like if Dr. Bruce Smith or Dr. Brown would tell us a little about the advances they have made in that direction in Ontario.

Dr. Bruce Smith: In our country any hospital refusing to admit patients suffering from tubercular disease, that refusal is reported and if on examination found to be correct, that hospital ceases to be regarded as a public hospital and does not receive support. Every general hospital we claim should be provided with facilities for the care of all tubercular patients. When a patient comes in distinctly hall-marked "Tubercular disease" there is no reason why the patient should not be provided with some isolated care, attended properly, where free air can be admitted. I do not know that I can add further to that. The question that Dr. Babcock was answering, I do not know with regard to delirium tremens. I think we are going to solve

that question very rapidly by the introduction in hospitals of continuous baths, learned from the Germans. That is the only method by which delirium tremens can be properly treated, and we are trying to get that introduced in every general hospital in every locality where there is a frequent occurrence of that disease. In tubercular cases, I say by all means admit them to a general hospital, give them isolated care, give them the balcony, if possible, or in many of our hospitals we have beds on the lawns, but do not refuse them. I find that as a result of this rule in our country that we are getting institutions established according to the ideal method of caring for tuberculosis, and that is the establishment of local sanitariums. When your hospital is compelled to care for them, you will stir up in that community the desire to make special arrangements, and as a result we get the separate institution.

Miss Jaquith: I do not think that in general enough attention is being paid to this matter of treatment of venereal diseases. We hear a great deal everywhere about tuberculosis and we hear very little about the other thing, and I do not think any hospital has really done its duty or any dispensary has really done its duty where a case of venereal disease in its acute stage has presented itself for treatment unless they either admit that patient and segregate the case for treatment, or send someone to that patient's home to see what the conditions are there and if it can be properly taken care of there. If it can, then it should be, because it saves the expense to the hospital and it is better for the public, but I do not think we are doing anything like our duty in protecting the public about those things.

Mr. Clark: In our new building we are planning for the care of venereal diseases practically along the line as you would for smallpox. We will be able to take care of them by units in the contagious department, which is on the roof. We will have our separate kitchen and will be able to isolate them completely, sterilizing all dishes and all clothes, so that they may be cared for from the general supply of food and linen and yet they will be in an entirely separate part of the hospital. This is being worked out by our hospital architect, Mr. Stevens.

A Visitor: When I was at home I read a book about the American hospital. It said every disease has a peculiar hospital

allotted for that kind of disease. After my good fortune or misfortune of crossing the Atlantic Ocean, I came to New York City. On the ocean I was sick and I did not know where to go, and as I did not know any English I could not make the man understand what I wanted. I showed him my eyes and throat. He smiled, and I thought he did not understand. After I landed they conducted me to the man with brass buttons, and I thought the brass buttons meant that he was a church officer, as I read in the book that no man can be a police officer in America unless he is a deacon of a church. So I said in perfect confidence that this Christian gentleman would not hurt me, so they took me to a hospital, put me in a little room, and lifted me up some place, and after I stayed there a day or two I did not know whether I was in America or some other island. Everybody came there with a tumor, either on one side of his face or the other, and I said that certainly it is very true what I read in the book that every institution in America has a particular disease to care for. The people had tumors, but I had not, and for a long time it was a puzzle to me that every man came there with a tumor in his face, but after a long time I discovered it was a tobacco tumor, and it was a revelation to me. As I understand, some of the patients had fallen down from the lumber yard, they could not understand English very well, and there were some diseases that they cared for and some that they rejected. I sincerely hope that the American people, who are the most splendid, painstaking people for the unfortunate, may establish more institutions for tuberculosis and that they may establish other institutions, so that every sickness may have a separate hospital; that the people may go there and get the treatment on the basis of humanity and not on the money basis.

QUESTION No. 2.—*Should each ward send its soiled linen direct to the laundry and receive it back from the laundry, or should all the linen be sent from the laundry to the general linen room for re-distribution?*

What is the best medium of disinfecting soiled linen, etc.?

MISS GOODNOW: I think some of the Massachusetts General people have tried both systems. They used to have the clothes sent to the linen room and they changed.

DR. BURLINGHAM: I cannot say very much about it. The

idea has been that with the central linen room we do not have quite so many pieces, but the work in the hospital is increasing so that the total of pieces of the laundry is going up. We think it prevents the storing of linen unnecessarily in the ward and, of course, saves a great deal of confusion in marking and that sort of thing.

Miss Keith: We adopted the central linen room system some six or eight months ago. When we were changing our wards we had the linen marked for the new department. On a certain day there were no reserve supply sheets in the linen room and three departments were calling for more. Two weeks from that day, under the central linen room system, we had two hundred sheets in the reserve on Saturday night when the linen had been given out for Saturday and Sunday, and every department was well supplied, with the same number of sheets that were there two weeks before in stock.

Miss Anderson: Will someone answer the second part of that question? What is the best medium for disinfecting soiled linen? Some of the women superintendents have an opinion on that. Dr. Smith, in his paper on the laundry, I think touched upon that. Perhaps his paper will answer the question. He spoke of the arrangement of tubs and the way the bundles were handled.

Question No. 3.—*Should nurses be taught to etherize (or anaesthetize) as a regular part of their training?*

Should charitable hospitals go to the expense of giving nitrous oxide gas and oxygen in their regular surgical work?

President: I think myself that it is desirable that nurses should be taught to give ether, but no more desirable than that internes in hospitals should also be taught to give ether and other anaesthetics. There are cases where a good many small hospitals require to have a knowledge of the giving of ether imparted to the nurses. Nurses frequently ask to give ether, and it has been a very crying wrong in almost all hospitals that so little attention has been paid to the subject of anaesthetics. I believe every hospital should have an anaesthetist and that this anaesthetist should teach carefully every person coming there, who has occasion to give ether, in the work. As to the duty of the hospital to give oxygen, I should say yes. I hope the time

will come when the majority of anaesthetists will adopt the use of the oxygen and nitrous oxide. It is much safer and it is the duty of every hospital to run as little risk as possible. Chloroform is dangerous, ether is dangerous, and the use of the nitrous oxide and oxygen is less dangerous.

Mr. Clark: I might say about the cost, I think a great many small hospitals fear that nitrous oxide is going to cost them more than ether, and they are slow about getting it. From my experience in the Lakeside in Cleveland, we have found that by charging the ward patients a small fee—those who are paying a fee for their ward care—and the private room patients more, we will find the nitrous oxide costs very little.

Dr. Walker: In our hospital we teach our nurses to give both ether and chloroform, and I think they ought to be taught, because very often in a small operation where you want an anaesthetic you may not be able to get any assistance except that offered you by the nurse. Some of the best anaesthetists I have ever seen have been nurses who have been brought up to it. Certainly they give excellent service.

Question No. 4.—*What at present is the best opportunity offered for expert instruction in the operation and management of hospital and sanitarium work, and what are the advantages offered?*

Dr. Babcock: I am frank to say that I cannot answer the question the way it is put. Most of you know, both the Massachusetts General and the Grace Hospital of Detroit and possibly two or three other institutions are attempting to train nurses for superintendents and hospital positions as supervisors. I do not want to have it understood that we are attempting to train hospital superintendents especially. We expect the graduates of our classes in hospital economics or the course in administration to take subordinate positions and work their way up. I might say our work has been very successful. Those of our graduates who desired hospital positions have them, and some of them have very good positions. The demand for candidates for vacancies is larger at times than we can supply, and I believe the instruction that we have been able to give them has been helpful to these women, although by no means such as we would like to give. We make it practical. They come in at the front door

and finish at the rear. They go through all the departments, work in conjunction with the heads of departments, who have been taught how to train these nurses. It is unfortunate that a larger number of hospitals do not attempt to do something of that kind. The resolution as presented yesterday by Miss Anderson looks toward a report, as I understand it, which may point out to other institutions the opportunities that they are missing in not training women, and men possibly, for this work. I want to say, as far as our institution is concerned, it has been a great help.

FIFTEENTH ANNUAL CONFERENCE OF THE AMERICAN HOSPITAL ASSOCIATION

To be held in the Copley-Plaza Hotel, Boston, Mass., August 26, 27, 28 and 29, 1913.

Active members shall be those who, at the time of their election, are trustees or executive heads of hospitals.

Associate members shall be executive officers of hospitals, next in authority below the Superintendent, or contributors to, or officers or members of any association, the object of which is the foundation of hospitals, or the promotion of the interest of organized medical charities.

All applications for membership shall be in writing and shall be endorsed by one or more members.

The annual dues for active members shall be $5.00; the dues for associate members shall be $2.00.

Application blanks can be obtained from the Secretary on request.

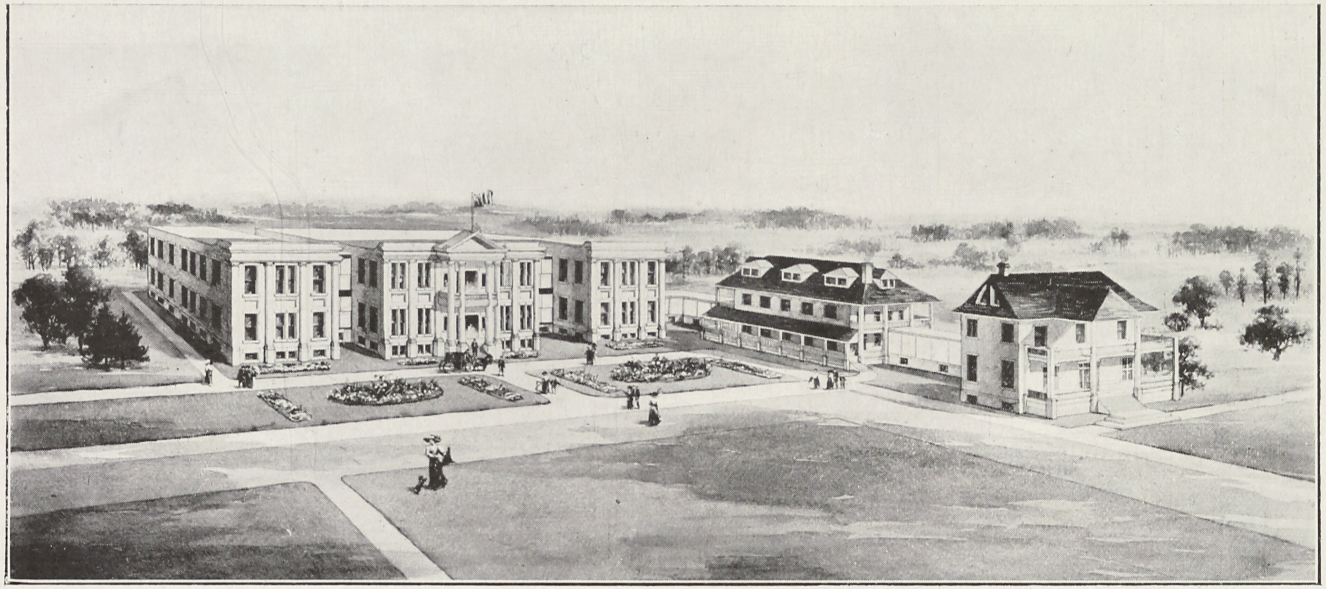
PROGRAMME.

Tuesday, August 26, 10 a.m.

Registration and Enrollment.

Morning session, 11 a.m.

1. Invocation—Right Reverend William Lawrence, Bishop of Massachusetts.
2. Address of Welcome—The Honorable John F. Fitzgerald, Mayor of Boston.



TORONTO FREE HOSPITAL FOR CONSUMPTIVES, WESTON, ONTARIO

3. President's Address—Dr. Frederic A. Washburn, Administrator, Massachusetts General Hospital, Boston, Mass.
4. Report of Committee on Medical Organization and Medical Education—Dr. Rupert Norton, Ass't Supt. The Johns Hopkins Hospital, Baltimore, Md.

AFTERNOON SESSION, 2.30 P.M.

1. Relation of Hospital Efficiency to the Efficient Organization for Home Nursing—Mr. Richards M. Bradley, Boston, Mass.
2. The Grading of Nurses—Miss Mary M. Riddle, Supt. Newton Hospital, Newton Lower Falls, Mass.
3. Report of Committee to Consider the Grading and Classification of Nurses—Miss Charlotte A. Aikens, Chairman, Detroit, Mich.

WEDNESDAY, AUGUST 27.

Section of Larger Hospitals in the Lower Amphitheatre of the Out-Patient Department at the Massachusetts General Hospital.

MORNING SESSION, 10.30 A.M.

1. Inspection and Standardization of Hospitals—Dr. John Allan Hornsby, Chicago, Ill.
   Discussion by Dr. Ernest A. Codman, Boston, Chairman of Committee on Standardization of Hospitals, Clinical Congress of Surgeons.
2. Record Keeping at the Massachusetts General Hospital—Dr. Byam Hollings, Ass't Administrator Massachusetts General Hospital.
3. Report of Committee on Hospital Construction—Dr. John M. Peters, Supt. Rhode Island Hospital, Providence, R.I.

WEDNESDAY, AUGUST 27.

Small Hospitals Section at the Copely-Plaza Hotel. Miss Mabel Morrison, Vice-President, Chairman.

MORNING SESSION, 10 A.M.

1. How the Small Hospitals May be Made Self-Supporting—G. W. Olson, Supt. Swedish Hospital, Minneapolis, Minn.
   Discussion.
2. Ambulance Service for Small Hospitals—Miss Margaret M. Moore, Supt. Jackson City Hospital, Jackson, Mich.
   Discussion.

AFTERNOON SESSION, 2.30 P.M.

1. What the American Hospital Association Can Do for the Hospitals of America—Mr. E. P. Haworth, Supt. The Willows Maternity Sanitarium, Kansas City, Mo.
   Discussion.
2. The Employment of Third Year Pupils as Special Nurses—Miss Mary Alberta Baker, R.N., Supt. St. Luke's Hospital, Jacksonville, Fla.
   Discussion led by Miss Nora D. Abbee, Samaritan Hospital, Ashland, Ohio.

EVENING SESSION, 8 P.M.

ROUND TABLE.

1. How counteract the pauperizing effect of charity hospital services for people who can pay partially or entirely, for their care?
2. Is a preliminary course feasible where the High School Standard for admission has not been fully adopted?
3. What are some of the advantages with paid instructors for the lecture course in training schools?
4. What is the most ethical means of advertising small hospitals?
5. Should not the use of typhoid serum be made obligatory in training schools?
6. The employment of nurses in preference to internes, as anesthetists.
7. The social side of training school life.
8. The prevention of disease among pupil nurses.
9. The relation of the hospital to the organized charities of a city.
10. How best secure the loyalty of nurses?

THURSDAY, AUGUST 28.

MORNING SESSION, 10 A.M.

Report of Membership Committee.
Report of Treasurer.
Report of Auditing Committee.

1. Report of Committee on Out-Patient Departments—Mr. Michael M. Davis, Jr., Director Boston Dispensary, Boston, Mass.

2. The Hospital and Dispensary and Social Reform—Mr. Sidney E. Goldstein, Director Free Synagogue, New York City.
3. Hospital and Asylum Workshops. Some Possibilities of Handicapped Labor—Dr. Herbert J. Hall, Marblehead, Mass.

AFTERNOON SESSION, 2.30 P.M.

1. National Insurance Act as it Affects Voluntary Hospitals and the Medical Profession of Great Britain. The Effects of the Insurance Act on the Hospitals of Germany—Dr. D. J. Mackintosh, Medical Supt. Western Infirmary, Glasgow, Scotland.
2. Certain Bearings Upon Hospital Problems of Compulsory Insurance and Workmen's Compensation—Dr. David L. Edsall, Massachusetts General Hospital, Boston, Mass.
3. (Subject to be announced later)—Conrad W. Thies, Esq., Honorable Secretary The British Hospitals Association, Westminster, S.W., England.

FRIDAY, AUGUST 29.

MORNING SESSION, 10.30 A.M.

1. Report of Committee on Hospital Finances and Cost Accounting—Dr. William O. Mann, Supt. Massachusetts Homeopathic Hospital, Boston, Mass.
2. The Private Patient's Relation to the General Service—Dr. Charles H. Young, Ass't Supt. the Presbyterian Hospital, New York, N.Y.
3. The Question Drawer—Conducted by Dr. Bruce Smith, Provincial Inspector of Hospitals, Toronto.

AFTERNOON SESSION, 2.30 P.M.

1. Report of Committee to Memorialize Congress to Place Hospital Instruments on the Free List—Rev. George F. Clover, Chairman, Supt. St. Luke's Hospital, New York, N.Y.
2. Report of Special Committee to Outline Standard Course in Hospital Administration—Dr. W. L. Babcock, Chairman, Supt. the Grace Hospital, Detroit, Mich.

Other Committee Reports:

Report of Committee on Time and Place of Sixteenth Annual Conference.



QUEEN MARY HOSPITAL FOR CONSUMPTIVE CHILDREN, WESTON, ONTARIO

Report of Nomination Committee.
Election of Officers.
Introduction of President-Elect.
Adjournment.

Officers, 1912-13.

President—Dr. Frederic A. Washburn, Administrator, Massachusetts General Hospital, Boston, Mass.
Vice-President.—Dr. W. P. Morrill, Benton Harbor, Mich.
Vice-President—Miss Mabel Morrison, Superintendent, Robinwood Hospital, Toledo, Ohio.
Secretary—Dr. John N. E. Brown, Superintendent, Detroit General Hospital, Detroit, Mich.
Treasurer—Asa Bacon, Esq., Superintendent, Presbyterian Hospital, Chicago, Ill.

Committees, 1912-13.

EXECUTIVE COMMITTEE AND COMMITTEE ON LOCAL ARRANGEMENTS.

Dr. William O. Mann, Supt., Massachusetts Homeopathic Hospital, Boston.
Dr. Joseph B. Howland, Assistant Administrator, Massachusetts General Hospital, Boston.
Dr. Frank H. Holt, Assistant Superintendent, Boston City Hospital, Boston.
Dr. Louis H. Burlingham, Assistant Superintendent, Peter Bent Brigham Hospital, Boston.
Miss Louise M. Coleman, Supt., House of the Good Samaritan, Boston.

MEMBERSHIP COMMITTEE.

Dr. W. P. Morrill, Supt., Winnipeg General Hospital, Winnipeg, Canada.
Dr. James C. Johnston, Supt., All Saints' Hospital, McAlester, Oklahoma.
Dr. Pliny O. Clarke, Supt., City Hospital, Wheeling, W. Va.
Dr. Thomas J. Charlton, Supt., Savannah Hospital, Savannah, Georgia.
Miss Alice M. Ruggles, Supt., Evanston Hospital, Evanston, Ill.
Mr. John Wells, Supt., Latter Day Saints' Hospital, Salt Lake City, Utah.

COMMITTEE ON CONSTITUTION AND BY-LAWS.

Dr. A. J. Ranney, Supt., Lakeside Hospital, Cleveland, Ohio.
Dr. A. B. Ancker, Supt., City and County Hospital, St. Paul, Minn.
Miss Nancy P. Ellicott, Supt., Rockefeller Institute Hospital, New York, N.Y.
Miss Winifred H. Brooks, Supt., Wesson Maternity Hospital, Springfield, Mass.

AUDITING COMMITTEE.

Mr. J. R. Coddington, Supt., Polyclinic Hospital, Philadelphia, Penna.
Mr. Reuben O'Brien, Supt., Manhattan Eye and Ear Hospital, New York, N.Y.
Dr. H. P. Frost, Supt., Boston State Hospital, Boston, Mass.

NOMINATING COMMITTEE.

Dr. W. L. Babcock, Supt., the Grace Hospital, Detroit, Mich.
Miss Mary L. Keith, Supt., Rochester General Hospital, Rochester, N.Y.
Mr. Wallace W. Kenney, Supt. Victoria General Hospital, Halifax, N.S.

PUBLICATION COMMITTEE.

Dr. J. N. E. Brown, Chairman, Supt., Detroit General Hospital, Detroit, Mich.
Mr. F. E. Moulder, Supt., the Harper Hospital, Detroit, Mich.

COMMITTEE ON HOSPITAL EFFICIENCY, HOSPITAL PROGRESS AND HOSPITAL CONSTRUCTION.

Dr. John M. Peters, Supt., Rhode Island Hospital, Providence, R.I., Hospital Construction.
Dr. William O. Mann, Supt., Massachusetts Homeopathic Hospital, Boston, Mass., Hospital Finances and Cost Accounting.
Dr. Rupert Norton, Asst. Supt., Johns Hopkins Hospital, Baltimore, Md.
Dr. Michael M. Davis, Jr., Director, Boston Dispensary, Boston, Mass., Out-Patient Department.

SPECIAL COMMITTEE ON BUREAU OF HOSPITAL INFORMATION.

Dr. Winford H. Smith, Chairman, the Johns Hopkins Hospital, Baltimore, Md.
Dr. S. S. Goldwater, Supt., Mount Sinai Hospital, New York, N.Y.
Dr. Henry M. Hurd, 1023 St. Paul Street, Baltimore, Md.
Dr. John O. Skinner, Supt., Columbia Hospital, Washington, Dist. Columbia.
Miss Minnie Goodnow, 9 Park St., Boston, Mass.

COMMITTEE ON NON-COMMERCIAL EXHIBITS.

Miss Minnie Goodnow, 9 Park St., Boston, Mass.
Dr. F. H. Holt, Asst. Supt., Boston City Hospital, Boston, Mass.

COMMITTEE TO MEMORIALIZE CONGRESS TO PLACE HOSPITAL INSTRUMENTS ON THE FREE LIST.

Rev. George F. Clover, Supt., St. Luke's Hospital, New York, N.Y.
Rev. A. S. Kavanagh, Supt., Methodist Episcopal Hospital, Brooklyn, N.Y.
Dr. J. N. E. Brown, Supt., Detroit General Hospital, Detroit, Mich.
Dr. W. L. Babcock, Supt., the Grace Hospital, Detroit, Mich.
Dr. Winford H. Smith, Supt., Johns Hopkins Hospital, Baltimore, Md.

COMMITTEE TO CONSIDER THE GRADING AND CLASSIFICATION OF NURSES.

Miss Charlotte A. Aikens, 722 Sheridan Avenue, Detroit, Mich.
Miss Emma A. Anderson, Supt., New England Baptist Hospital, Grand Rapids, Mich.
Miss Ida M. Barrett, Supt., Union Benevolent Association Hospital, Grand Rapids, Mich.
Dr. R. W. Bruce Smith, Inspector of Hospitals, Toronto, Ont.
Dr. P. E. Truesdale, P. E. Truesdale Hospital, Fall River, Mass.

SPECIAL COMMITTEE TO OUTLINE STANDARD COURSE IN HOSPITAL ADMINISTRATION.

Dr. W. E. Babcock, Supt., the Grace Hospital, Detroit, Mich.
Dr. Jos. Howland, Asst. Supt., Massachusetts General Hospital, Boston, Mass.



ENTRANCE TO THE SHIELDS EMERGENCY HOSPITAL, UNIVERSITY AVE.

AMERICAN MEDICAL ASSOCIATION

The American Medical Association met this year in Minneapolis, on June 17, 18, 19. The programme of the Section on Hospitals was as follows:

Officers of Section—Chairman, H. B. Howard, Boston; Secretary, John A. Hornsby, Chicago.

TUESDAY, JUNE 17—2 P.M.

Chairman's Address—H. B. Howard, Boston.

SYMPOSIUM ON HOSPITAL ARCHITECTURE.

The Trend of European Hospital Architecture—Edward F. Stevens, Boston.

Architecture of the Great Charity Hospital—Richard E. Schmidt, Chicago.

Architecture of the Modern Hospital for Contagious Diseases—L. A. Lamoreaux, Minneapolis.

Equipment of a Small Hospital. Making Over a Dwelling House—John Allan Hornsby, Chicago.

WEDNESDAY, JUNE 18—9 A.M.

Selection of Hospital Help under Civil Service Rules—Leonhard Felix Fuld, New York.

Administration of the Great Charity Hospital—Rupert Norton, Baltimore.

Hospital and Asylum Work Shops: Some Possibilities of Handicapped Labor—Herbert J. Hall, Marblehead, Mass.

Possibilities in the Routine Practice of a Small Hospital—Herbert C. Cole, Bogalusa, La.

The Psychopathic Idea—E. E. Southard, Boston.

Report on the Present Status in the Campaign for the Standardization and Classification of Hospitals—Henry M. Hurd, Baltimore.

THURSDAY, JUNE 19—9 A.M.

SYMPOSIUM ON TRAINED NURSING.

Efficiency Versus Routine in Hospital Nursing—W. Gilman Thompson, New York.

The Trained Nurse from the Standpoint of the Attending Surgeon—Arthur Dean Bevan, Chicago.

The Trained Nurse of the Future—Richard O. Beard, Minneapolis.

The Nursing Situation as It Is To-day—Joseph B. Howland, Boston.

DR. HELEN MACMURCHY OF TORONTO IS APPOINTED TO A NEW OFFICE

Hon. W. J. Hanna, Provincial Secretary, has created a new position in the hospital branch of his department, that of Inspector of Feeble-minded and Assistant Inspector of Hospitals and Charities. To this work Dr. Helen MacMurchy of Toronto has been appointed.

The duties of this office will be to inspect all prisons and public charities and give particular attention to the custodial care of the feeble-minded. Dr. MacMurchy will visit county houses of refuge, industrial houses of refuge and orphanages in different parts of the Province.

Dr. Bruce Smith has been in charge of this work heretofore, and Dr. MacMurchy's appointment will enable him to give more attention to the medical side of asylum and hospital practice than he has been able to do in the past.

Dr. MacMurchy has given much study to the question of caring for the mentally deficient, especially women and children, and her various reports have awakened widespread interest among many who have been impressed with the need of remedial steps being taken for providing more advanced treatment for this class. Dr. MacMurchy's appointment is among the first, if not the first, of its kind on this continent, that has gone to a woman. In her work she will have charge of male as well as female patients.

A daughter of the late Archibald MacMurchy, LL.D., Dr. MacMurchy herself holds many high academic honors. She is a graduate of the University of Toronto, an M.B. of the Medical College for 1900, and an M.D. for 1901. During the intervening years until the present she has carried on a general practice and has lectured as well on anatomy, physiology and kindred subjects. In 1906 she prepared a census of the feeble-minded in Ontario, was elected President of the Women's University Club in 1905, and Vice-President of the Charities and Correction Association in 1908. A delegate to the British Medical Association Congress in 1909, Dr. MacMurchy was appointed by the Provincial Government to represent Ontario at the first International Conference on Infant Mortality at Baltimore the following year. Her report on infant mortality in 1911 was highly eulogized in Great Britain. In 1911 Dr. MacMurchy was appointed one of the medical inspectors in Toronto public schools, but resigned the following year after a heated controversy arising out of her condemnation of the methods employed.

DINNER OF EX-HOUSE SURGEONS

The annual dinner of the former house surgeons of the Toronto General Hospital, held on June 19th at the Albany Club, was graced with the presence of Dr. Taylor of Goderich, the oldest living house surgeon in Ontario, and Dr. Charles O'Reilly, who was medical superintendent from 1876 to 1905.

When Dr. Hillary, the President, called the gathering to order there were eighty ex-house surgeons seated around the festive board, the largest assemblage in the history of the organization.

Dr. Hillary in his opening remarks called attention to the fact that the new General Hospital, the largest and finest equipped on the North American continent, was to be formally opened on the birthday of Dr. Charles O'Reilly, who for many years labored in the old hospital. The remark was received with prolonged cheers. Dr. Hillary also read a paper dealing with the history of the General Hospital, covering many interesting features, dating back almost to the inception of the institution.

Following this interesting incident, Dr. O'Reilly gave a brief talk covering his connection with the institution, during which he made comparisons of the obstacles which the house surgeons had to contend with before the introduction of the modern medical equipment, which has been instrumental to a large extent in elevating the work of the institution to a position scarcely thought possible a few years ago.

Dr. W. E. Gallie, of Toronto, was presented with a gold-headed cane for contributing the best essay on "Modern Medical Science," a prize which is given annually by the Association. Dr. Thos. Cullen, of the Johns Hopkins Hospital, Baltimore, was the runner-up in the competition, in which some twenty-five house surgeons competed.

The speakers who responded to the different toasts were: Dr. Nevitt, Dr. Doolittle, Dr. N. J. Yellowlees, Dr. R. K. Haywood, Dr. Phillips, Dr. Eddie Robertson, Dr. C. K. Clarke, Superintendent of the General Hospital, and Mr. J. C. Eaton.

Hospital Intelligence

Kootenay Hospital

A new building is being added to the Kootenay Lake General Hospital by Architect Alex. Carrie. J. A. Irving, of Nelson, is chairman of the Board.

Bowmanville Hospital

A new hospital has been opened in Bowmanville, Ont., with much eclat. The superintendent is Miss Mabel Bruce, a graduate of Bellevue Hospital.

Union is Strength

All the hospitals of Calgary are uniting under one joint board. Hospital subscribers and physicians are to have seven representatives on the board and the city six.

Brandon's Activity

One hundred thousand dollars' worth of buildings are to be added to the Brandon General Hospital—a ward, and additions to the maternity and surgical building; also the nurse's home Charles Whitehead is the president.

Perley Memorial

Hon. G. H. Perley has presented to the Ottawa, Ont., Anti-Tuberculosis Association a splendid building for the care of incipient cases of tuberculosis. The hospital was opened by H. R. H. the Governor-General. Dr. Friedmann was also present.

Still Another

Walkerville, Ontario, is building a $50,000 hospital. The site is being donated by the Walker firm, the well-known whiskey distillers.

Another

A new hospital is being built in Stadacona, Quebec, by Theo Leclerc.

Public Health and Hospitals

In British Columbia, hereafter under the terms of the "Hospital Act Amendment Act," just introduced in the Legislature by Hon. Dr. Young, Provincial Secretary, all municipalities will be required to pay to hospitals treating indigent patients originating from within their municipal boundaries for the care and treatment of such patients at the rate not higher than one dollar per day. Provision is made that municipalities can make a fixed grant to hospitals in lieu of liability for maintenance of patients, and where no such agreement is made the hospital shall notify the municipality affected of the arrival of patients at the hospital who claim residence in the municipality so notified in order that the municipal officers may be able to look up the identity of the patients. Where a municipality settles the bill of any of its residents the charges become a liability on the patient, his executors or administrators as a debt due the municipality.

The control and regulation of all private hospitals is taken by the Government under the Act. All such hospitals must be licensed. Before a license will be issued, the private hospital must pass inspection by an officer to be appointed by the Government. Every financially aided hospital is required to provide reasonable facilities for giving, by such of its staff as may be designated professors and members of the staff of the Medical Faculty of the University of British Columbia, clinical instruction in its public wards to medical students of the University.—*Western Canada Medical Journal.*

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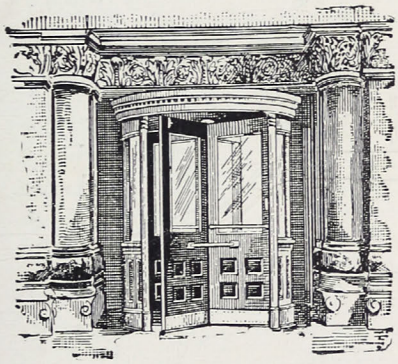
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Hospital Authorities know that the protection of patients from draughts and noise should be one of the first considerations in the hospital ward. This can be successfully accomplished by the use of

REVOLVING DOORS

They maintain an even temperature.

They economize coal.

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They are not only convenient, but safe.

They revolve easily and collapse easily.

For these reasons they are **Particularly Adaptable to Hospitals, Sanatoria and Asylums.**

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G. W. Gaden, Manager. To whom all correspondence must be addressed.

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NEW HOSPITAL APPLIANCES, PHARMACEUTICAL PREPARATIONS, ETC.

Indispensable to Hospital Boiler Rooms

Attention is called of all hospital officials to the advertisement of the Canadian Steam Boiler Equipment Company, page li, who manufacture the Cyclone Shaking and Dumping Grate Bar.

This style of grate bar is a boon to hospitals and institutions where it is absolutely necessary to keep down all dust and gases which are so common in many boiler rooms. With the Cyclone Grate Bar, the fireman has ash pit door and fire doors closed when cleaning fires, against the old way of drawing red hot ash and clinkers on to the boiler room floor, and then cooling them down with water with the attendant steam, gas and dirt which naturally find their way into other parts of the building.

Besides these advantages they give a saving in fuel and are much easier on the fireman.

The Lister-Bruston Lighting System.

Hospital Superintendents, whose buildings are in smaller towns and removed somewhat from centres of population, will be interested in the Lister-Bruston System of Lighting, which is so essentially suitable for small hospitals. The following extracts will go to show just what it is:

Extract from *Sanitary Record.*

As an instance of compactness, we may make passing mention of the automatic electric generating plant manufactured by Messrs. R. A. Lister & Co., Ltd. It consists of a petrol or gas engine, a dynamo, controller and safety switchboard. It is quite automatic in action. By merely turning on the switch the apparatus is set in motion, and electricity is at once supplied, by turning off the switch the machinery is closed down. It is, therefore, both safe and economical, and for this reason is admirably *adapted for hospitals, asylums,* schools, institutions, and even small villages. The attendance on the plant is reduced almost to nothing.

Extract from *Country Life.*

Those who are in search of a lighting and pumping plant will be interested in that manufactured by Messrs. R. A. Lister & Co., Ltd. The generation is entirely automatic, being controlled by the switching on or off of the lights. No attention is required beyond what is involved in cleaning, lubricating and filling the petrol tank; and the current being delivered direct from the



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A PURE, FULL TEST peroxide of Hydrogen that meets every requirement of this useful solution.

EVERY PHYSICIAN has become acquainted with the unscrupulous methods by which peroxide of hydrogen is often prepared and sold; how often it goes out in second hand bottles; how often it fails in test at the time of sale.

HYDROX is guaranteed 3 per cent. 10 volumes as the consumer gets it. It is prepared with the utmost care by the nitrate barium binoxide process—no cheap chemicals—and absolutely pure.

In fact, our specific aim has been to give the best reason for its preferred use by the most exacting medical men. To this end we have spared no pains, either in the process itself—in the matter of the highest grade materials, in the fullest laboratory care, or in the bottling.

HYDROX is Peroxide of Hydrogen at its best, more than meeting the U.S.P. demands; always full weight; an economical peroxide when you consider the weight, the strength, and the new, carefully treated bottles.

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dynamo, and the usual accumulator wastage avoided, thorough efficiency and economy are ensured.

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A Mineral Rubber Floor Particularly Suitable for Hospitals

While ordinary asphalt floor is readily softened by heat, natural or artificial, the Sarco Mineral Rubber floor remains sufficiently unaffected to render satisfactory service. Cold that will cause asphalt floor to contract and crack does not affect the Sarco floor. In buildings where an objectionable odor or taste is imparted by the ordinary asphalt floor the Sarco Mineral Rubber floor can be used with perfect satisfaction, since it has neither odor nor taste to affect the most delicate product.

Most important of all, the characteristics of the Sarco Mineral Rubber are permanent and give the floor toughness, waterproofness and durability far in excess of ordinary asphalt.

If you are in search of a solution of your flooring troubles where wood or concrete does not stand the wear, put in a trial Sarco floor.

If joints and unevenness of blocks, brick or tile floors catch dirt use a jointless floor.

If you have experienced difficulty or dissatisfaction with asphalt floor you will find that overcome by Sarco Mineral Rubber floor.

To summarize, Sarco Matrix is perfectly non-absorbent and, being unchanged by heat or cold, its use results in just the proper degree of hardness in the floor.

Vacuum Heating

In no other class of buildings is the question of heating to be more seriously considered than in hospitals.

Vacuum heating is not a complicated system, as many suppose. The heating system proper consists of boilers for generating the steam, main supply pipes for conducting steam to the various radiators, radiators for giving off the heat to surrounding air and objects, and a return system of piping for conducting water of condensation back to boiler again. In addition, each radiator is equipped with various valves for controlling and regulating the supply of steam to the radiating unit. Experience has demonstrated that none of this apparatus can be dispensed with in a perfect system.

In the old systems of heating there were many inherent defects impossible to eliminate except by changing to a vacuum

The New Toronto General Hospital

IS a marvel of completeness to the most minute detail. Nothing has been neglected in the perfecting of the most up-to-date hygienic, sanitary and perfect institution of the kind on the Continent, if not in the world and the Board has the gratitude of the great public at large, not only of Toronto and Canada generally, but of the hospital workers of the entire country, who regard this as a model.

The drinking water supplied to the patients is produced by the TRIPURE Sanitary Water-Still process, in use by the United States Government in their Army and Naval Hospitals and Departments, War Vessels, etc.

This water is distilled and triply purified and oxygenized during vaporization, making it potable, palatable and delicious—really an artificial rain water—and is absolutely pure and sterile—so pronounced by the World's Congress on Hygiene and Demography.

TRIPURE Water will be frozen in Carafes in the most up-to-date manner by a Kent Ice Machine, thence to be delivered at the bedside of individual patients.

The installation of these two standard plants in a building specially built and designed for them demonstrates the infinite attention to detail and convenience of operation and to the comfort of patients which has been lavished upon the work.

The Sanitary Water-Still has been adopted, as it is the only Water-Still which returns to the vapor all the oxygen removed in the boiling, thus doing away with the flat and insipid taste found in all other distilled waters. The cost of operation is practically nil and the space occupied—often a desideratum in compact work—is no more than used by an ordinary kitchen hot water tank, and requires no expert care or attention.

The Sanitary Water-Still Co. of Canada, Limited, is prepared to figure on all hospital work and furnish apparatus producing from 125 gallons per 24 hours up to 10,000 gallons.

Address, 136 John Street, Toronto, Ontario,

Telephone Adelaide 420.

Sanitary Water-Still Company of Canada, Limited

system. A few of these defects were: Air binding, water hammer, short circuiting of steam, and thus steam waste, and numerous others.

The Vacuum System affords means for creating a "pull" or vacuum on the return system, while the boilers create a "push" or pressure on the supply, thus steam moves from medium of higher to that of lower pressure, "same as water flows down hill." By the correct application of steam traps to the radiators all air and water are removed to the various return pipes, leaving the radiators full of steam. Steam traps hold the steam in the radiators until it has liberated all of its heat units, thus eliminating any possible waste; water is removed from radiators without noise; there is no sizzling or sputtering of air valves, and there is perfect control of the system at all times by admitting as much or as little steam to your radiators as you need to suit weather conditions.

The secret of a successful vacuum system of heating is the steam traps for the return ends of the radiators. A trap that will close off against steam but will open to pass water and air; that will do these things as regularly and untiringly as does nature's law of gravitation manifest itself, is the trap that should be used.

There is such a trap on the market.

The C. A. Dunham Co., Ltd., whose advertisement appears on another page of this journal, will furnish you more details and information.

The Use of Asbestocement in Hospital Buildings

To the hospital builder, Asbestocement in its various forms offers three most important advantages—it is absolutely fireproof, practically everlasting, and perfectly sanitary. Incidentally, it is also most attractive in appearance.

Asbestocement is a mixture of the best Portland cement and asbestos fibre, formed under enormous pressure into Asbestoslate shingles, Asbestos building lumber, and Linabestos, for interior wall and ceiling finish.

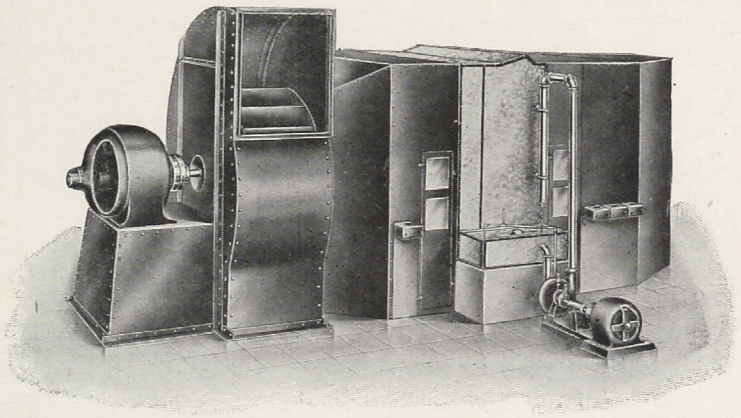
Asbestoslate Cement Shingles are made in various shapes and sizes, those most commonly used being 12x12 inches and 16x16 inches. They are generally laid diagonally, and in their beautiful shades of Newport grey, indian red and blue black they make decidedly handsome roofs.

Asbestos building lumber and Linabestos are made in standard flat sheets 42x48 inches and 42x96 inches. The building lumber is from $\frac{1}{8}$ to $\frac{5}{8}$ inch thick, and the Linabestos 3/16 inches thick. The building lumber is Newport grey, smooth in finish, very hard, and, like Asbestoslate shingles, it grows harder and

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FOR

HOSPITAL VENTILATION



Steel Plate Fan with Direct Connected Motor, Tempering and Re-heating Coils, and Air Washer, which is operated by an Electrically Driven Centrifugal Pump.

This Fan is the ultimate design of the Multivane type of Fan Construction, and is now specified by all the leading Architects and Contractors. It is the only Fan equal to present conditions of ventilation, and when operated with our improved system of Air Washing it is admitted to be the most modern and approved production in the Fan World.

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tougher with exposure to the elements. Linabestos is lower priced, not so hard, and is intended for interior finish only.

Asbestoslate shingles are admirably suited for any hospital building, as they protect from fire originating in neighboring buildings.

Asbestos building lumber and Linabestos are particularly adapted for hospital cottages, an ideal construction for which is a roof of Asbestoslate cement shingles, outside walls of Asbestos building lumber, and inside walls of Linabestos, either panelled or finished with a skim coat of plaster. Such cottages are fireproof, sanitary and almost everlasting.

In the cottages erected by the Pennsylvania State Sanatorium for Tuberculosis at Mont Alto, Asbestoslate cement shingles and Asbestos building lumber have been very extensively used, with most satisfactory results.

These Asbestocement products are made by the Asbestos Manufacturing Co., Ltd., whose factory is at Lachine, Quebec, and offices in the E. T. Bank Bldg., 263 St. James St., Montreal.

Pride of the Kitchen Hospital Soap

This famous soap has been on the market for nearly fifty years, and used for the last decade not only by the United States Government officials under contract, but State institutions as well. Now that the high cost of living has created the necessity for saving on the purchase price of scouring soaps, scouring and washing powders, articles in daily use in homes, hospitals, hotels and public buildings, all desiring a superb product at rock bottom prices should write to the Pride of the Kitchen Company, Brooklyn, N.Y., the sole manufacturers of these popular cleansers.—Ed.

Paripan Lacquer Enamel

The effectiveness of the decorative scheme at the Toronto General Hospital is good, the colors are soft and pleasing. To obtain this result "Paripan" lacquer enamel has been exclusively used. This is an English enamel of exceptional quality. Its reputation is such that it is entitled to the consideration of all hospital authorities. Guys, London (on which 16 acres of wall surface are treated with Paripan), King Edward the Seventh Sanatorium, and the majority of large English hospitals, are treated with "Paripan," and walls treated from 10 to 20 years ago are in perfect condition to-day after repeated washing.

Sturgeons Limited, Toronto, are the agents.

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C. H. BURGESS & COMPANY
Traders' Bank Building - - Toronto, Canada

Metallic Conduits for Interior Construction

Of late there has been an ever increasing demand for metallic conduit for interior construction, Conduits Company, Limited, the largest manufacturer of interior conduit in Canada, realized some years ago, that the most efficient conduit for interior construction was a soft steel tube, thoroughly cleaned of silicates, scale and burrs, and protected from oxidation and corrosion by either an enameled or galvanized surface—the result being our present "Loricated" of the enameled type and "Galvaduct" of the galvanized type.

"Loricated" Conduit is a mild steel welded tube, enameled inside and outside, and is manufactured solely by Conduits Company, Limited; "Loricated" is the trade name of the particular brand of enameled conduit produced by them, and is registered in the Department of Agriculture. All "Loricated" conduit is so labeled, and users should see that they receive the genuine article.

"Galvaduct" conduit is likewise manufactured solely by this company under letters patent. Its surface is thoroughly galvanized and the tube is then treated on the interior only with their special flexible enamel. This name is also registered.

As it is this company's desire to constantly improve their products the public may safely rely on the continued standard of this class of electrical goods.

An Important Consolidation of Interests

A combination has been effected, of three chemical manufacturing concerns, that will result in benefits to the medical profession because of the lessened cost of production and improved quality made possible by a larger output and better facilities.

The new company, recently incorporated, is known as the Hydrox Chemical Co. Its only subsidiaries are David B. Levy, Inc., and The Middletown Chemical Co.

None of the individuals formerly connected with the Hydrox Chemical Co. or the Middletown Chemical Co. is connected with the newly incorporated company. The assets and trade names of these companies were bought by capitalists and experienced chemical manufacturers who have introduced modern methods of efficiency in manufacturing and selling.

David B. Levy, well known as a successful manufacturer of chemicals, is now treasurer and general manager of the Hydrox Chemical Co. The plant of David B. Levy, Inc., in the Bush Terminal, Brooklyn, has been added to the other laboratories of the company situated in Chicago, San Francisco and Toronto.

The President is Schuyler Lestrade, at the head of a group of New York financiers, who have assured the company's success. An aggressive campaign of "ethical" publicity is being used to inform the profession and the public regarding the numerous valuable uses of Hydrox Certified Peroxide of Hydrogen.

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It is expected as a matter of course that the ordinary roof has sooner or later to be repaired or replaced.

The roof of ASBESTOSLATE Cement Shingles is ***permanent.***

ASBESTOSLATE Cement Shingles are made of best Hydraulic Cement and Asbestos, and are practically indestructible. They continue for years to grow harder, tougher and more impervious to moisture. They are fireproof, and absolutely weather-proof under any climatic conditions, never needing paint or preservative.

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Give her BOVRIL

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the Body-Building Power of Bovril has been proved to be from 10 to 20 times the amount taken.

A Credit to Toronto

Elsewhere in this Journal will be noticed the advertisement of the Toronto Silver Plate Company, Limited, whose factories and salesrooms have been situated at West King St., Toronto, since the year 1882, although since that date the factories have been rearranged and enlarged from time to time so as to keep pace with their increased business. Their present factories have just about reached their limit of output and several months ago additional land on Adelaide Street, abutting their King St. property, was purchased with the idea of putting up in the comparatively near future additional factory buildings.

Additional to the manufacture of what might be termed home table silverware, including knives, forks and spoons (in an absolutely guaranteed quality of plate), as well as in Sterling Silver, the Toronto Silver Plate Co. for years have been noted for their Hotel, Club, Hospital, Steamboat and Dining Car Silverware, which they make a specialty of, and which will be found in general use from the Atlantic to the Pacific.

The Toronto Silver Plate Co. not only do an exceptionally large trade in the Canadian market, but do considerable of an export trade, which was first established from their London, Eng., Show Room, 23 Thavies Inn, Holborn Circus, and afterwards for several years by direct representation when the London, Eng., Show Room was discontinued.

The Toronto Silver Plate Co. are strictly an independent company. Not in the trust or members of any Silverware Association or combine, in that way are perfectly free to determine their business policies.

In connection with hospitals, Catalogue No. 25 illustrates a class of goods very suitable, absolutely guaranteed as to quality and at a reasonable price, and which catalogue is furnished to any responsible party on application.

Eddy's New Nonpoisonous Match

It is the "Sesqui." So perfect a match has never before been produced in Canada. Over sixty years of endless endeavor are back of this new "Sesqui." It is the "last best" match of Canada's Master-makers.

The features of Eddy's famous white-tipped "Silents" have all been retained. The new "Sesqui" possesses silence and safety unsurpassed.

But it has one feature that marks a new era in match manufacture. Eddy's "Sesqui" match is *absolutely unpoisonous*. The secret composition used in tipping the strong pine sticks renders it (to adults and children alike) absolutely harmless.

Can be procured anywhere. Marketed in three distinct editions—regular, pocket, home special.

The Hospital World

BUFFALO, U.S.A. TORONTO, CANADA LONDON, ENG.

An International Journal published in the interests of Hospitals, Sanatoria, Asylums, and Public Charitable Institutions throughout America, Great Britain and her Colonies.

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Editorials

THE GREATER SERVICE

CONSIDERABLE discussion has taken place in the New York legislature, New York hospitals, and all of the recent numbers of nursing journals, concerning the nursing bill which was recently presented to the above named body, but fortunately thrown out.

One of the chief objects of the bill, as inspired by certain nurses of New York State, was to prevent

any woman from calling herself a "nurse," unless she had secured a full term training in a large general hospital.

The nurses of the state had been busy for months in the endeavor to secure support for this bill, and had a strong lobby at the Capital. The aim was to put such schools as the Chatauqua, and those belonging to special hospitals, out of business. A hard blow was aimed at the latter by the endeavor to deprive their nurses of their right to use the title to describe the service they perform.

The defeat of the bill in this form is not a matter of regret. It is generally admitted that nurses graduated from these correspondence, short-term and special hospitals are not well and thoroughly trained, but the deletion of the term "nurse" will not remedy the matter. The sick must be served by someone, and the one engaged for this service will always be called by the age-old and familiar word. By length of time and service it has grown to belong to the ranks of the people, and no bill passed, no efforts of professionalism, will keep the common citizen from using it in the sense they are accustomed. It would be easier for the highly graduated professional nurse to find a new term to indicate her rank and calling.

The rank and file of the people need nursing—plain, average, careful nursing. They cannot, by reason of cost, retain the services of highly-cultured, three or four year graduates, trained to the finger tips in all medical and surgical service. They do not often require one so specialized. They can afford and

do need the nurse who has obtained the briefer, but not necessarily lesser, training in general knowledge, one who has, possibly, as great a share of common sense and good judgment, and whose service is often prompted by a measure of sympathy that does not wait on the dictates of professionalism.

The whole nurse-movement is an organic thing that cannot be greatly influenced in its development by statutes, rules or registrations. It is the outcome of a great human need. The great body of nurses are ready to respond to that need, and will not support the trades union organization which a few are trying to establish.

A ZONE OF QUIET

WHILE a hospital should always be a place of cheer it should always be, as far as possible, noiseless.

Many people consider noise to be an essential expression of cheerfulness—that to be cheerful means much talk, laughter and sound in general. This is perhaps especially the case with people of the lower and more primitive class and of emotional nationalities.

Such a conception must be fought at every turn in the hospital administration, and noiseless service placed as a big factor in efficiency.

Noise within the hospital is under the control of the management. Precept upon precept is necessary to reduce noise to its minimum. The bustling young

interne and sturdy nurse probationer, fresh from the college campus and the country home, must be taught to control voice and step, as they move through the wards, and to appreciate in some degree the sensitive sick nerves which they themselves have never known.

Housemaids, ward-tenders, and all subordinate workers should be taught to work quietly. Visitors should have the word of admonition impressed upon them at the entrance door, to step lightly and speak in low tone.

Various devices are being constantly introduced to lessen noise. Rubber heels on shoes, for those who serve in the wards; rubber mats placed in the bottom of the dish-washing sink; wheels with rubber tires on beds and stretchers, also door hinges well oiled; windows and doors supplied with rubber checks to prevent slamming. Annunciators, in the form of bells and buzzers should be relegated to the scrap heap, and light signals used instead. Injunctions to silence may be posted in the corridors.

Noise without the hospital grounds is under municipal control. In large cities and towns where the hospital has no grounds between it and a public thoroughfare some municipalities have established what is termed a "zone of quiet," which is indicated by signs set up a block distant from each corner of the hospital.

Express and draymen are required to walk their horses within this zone. Automobile drivers cover their mufflers, and must not sound their horns. Hawkers and peddlers do not shout their wares, and the

hurdy-gurdy music is forbidden. It must be admitted, however, that unless strict vigilance is exercised by the authorities, custom soon stales the written injunction, and it is apt to be disregarded.

When the evil result of noise, especially upon the sick, is brought persistently, and in a practical way, before the people, they are found willing, as a rule, to make response.

Education is the great factor in producing satisfactory results in this, as in other advances. But, in the meantime, the eternal vigilance of the hospital administrator can accomplish much.

AN ARCHITECTURAL INFLUENCE

THE influence of hospital architecture as a hygienic force in the construction of the church, the school, the factory, the office and the home is becoming greater every day.

Medical science has long insisted that the highest known hygienic conditions shall prevail in the hospital—that the sick may have every chance to get well. Every detail of construction and equipment is planned and carried out with this end in view—tile floors, washable walls, curved corners, avoidance of ledges, simplification of trimming and draperies, large window panes, the plain door with glass knob, radiators and all fixed apparatus out from the walls and the like.

And in the matter of furnishings also, the simple

sanitary bed, the open bedside table, the sloping-topped cupboard, the smooth dishes and instruments, these and a score of other studied utilities are devised to protect the patient and speed the cure.

The public health campaigns of recent years, carried on by health boards, physicians, sanitary engineers and others, have awakened the people to hygienic values, and they are beginning to ask why the conditions and surroundings that make for the recovery of the sick should not be employed in helping to maintain health in those who are well.

Citizens are demanding for their offices and homes similar attention to details of sanitary construction. Halls and churches are being better ventilated, schools are better lighted, the plumbing of kitchens and bathrooms is more open and cleanly. Numerous small hygienic devices are employed, which attest to the growing knowledge of the individual citizen of the danger of germs, and the meaning and value of sterilization.

The hospital architect, the hospital expert and the physician embody the results of their special knowledge and research in the modern hospital. The highest conception of sanitary construction and hygienic conditions exists or should exist in the hospital of to-day. From the expensive home to the one of moderate cost, and from that to the home of the working-man, the hospital in their midst stands as an object lesson in sanitary architecture, and a leader in all that appertains to health-giving conditions.

THE SUPERINTENDENT'S VACATION

BRAND WHITLOCK, in a recent magazine article, tells how a wise directorate, in engaging a business manager who would carry great responsibility, stipulated that he should have a salary of $8,000 for working twelve months in the year, but $10,000 if he worked for ten months only.

The directorate clearly believed that ten months work plus two months' holiday achieves better results than twelve months' work and no holiday.

The value of the vacation lies not alone in the physical recuperation afforded, but in the wonderful manner in which it readjusts the mental attitude. "Hold things in their proper proportion," adjures Drummond repeatedly, in his addresses to young men. It is the keynote of all sane and wise living.

No man can work twelve months in the year—certainly, no hospital superintendent can—without losing in greater or less measure his sense of proportion. The daily friction, the petty mishaps or the more serious blunders of a large staff, the constant dealing with humanity-on-edge in the patients and their friends, the financial problem and the larger questions of organization—all go to make the position of chief administrator one of continuous strain. And the more faithful and conscientious he is, the greater the danger that these things will speedily loom too large, darkening and foreshortening all his outlook upon life.

Of course, no hospital head should forego the

daily and weekly relax of hours and half days or week-ends off, when the little trip into the outside world and its other interests eases the strain and tones the system. But these do not give the absolute rest of the longer holiday, since the responsibilities of office are still carried. The longer annual holiday, with its necessary shifting of authority to another, means that the superintendent sheds all care and becomes absolutely free.

The return for a last direction, advice or caution; the sense of delinquency in leaving; the feeling that one's personal oversight is essential to the well-being of the institution—all are evidences that the sense of proportion is lost. And the readjustment begins even as the train moves out of the station, when the superintendent with a deep breath that betokens the extent of his relaxation, realizes in thought, if not in words, that he "is out of it; no matter what happens."

As the holiday progresses, he prophesies that "likely things will go all right anyway." Finally, he comes to a point where he admits that possibly the hospital wouldn't suffer, even if he never returned to it.

Also he finds that "The world is so full of beautiful things," that life is worth while quite apart from the hospital and its problems. The latter has dropped from its position as the greatest thing in the world to its place as one among numerous other great things. And when this stage is reached, the superintendent's sense of proportion has become readjusted, and he is fitted, mentally at least, to resume his responsibilities.

The point in the opening paragraph is well made. The superintendent who works ten months in the year, and gives the remaining two months to a wisely used vacation—change of scene, change of air, change of thought—is worth more to his Board than is the all-the-year-round worker.

For he retains the true proportion of things.

A HOSPITAL CONFERENCE

The second meeting of the Hospital Section of the American Medical Association was most instructive. It is an excellent thing that this important body with its membership of thousands of physicians and surgeons should have a section devoted to hospitals, since the relation of the profession to the same is a very close one.

As a rule the medical men know little or nothing respecting hospital construction and management unless they are on a hospital staff, in which case they are interested in the medical staff organization, but their point of view is, naturally, somewhat biassed toward the line of personal advantage.

It is time that the profession took interest in the construction of those institutions where its members so largely carry on their practice, that they should understand and know the best in hospital wards, laboratories, and kitchens, and, from the standpoint of hospital finances, it is equally time that they should learn something respecting the economical use of hos-

pital supplies of all sorts, and the general running of the institution.

*By reading the transactions of the hospital section, the members of this great medical organization will become familiar with phases of hospital life.

The proceedings will be published in full, and a copy of them should be in the hands of every member of the association. Dr. John Hornsby, the Secretary of the Section, will be able to supply a limited number.

Dr. H. B. Howard presided, and added much to the success of the meeting by his informal, homely practical deliverances, born of a study of all sides of hospital life.

The first day was devoted to papers by several hospital architects who are building hospitals—Stevens, of Boston; Schmidt, of Chicago; Lamoreaux, of Minneapolis, and Stratton, of Detroit. Stevens, fresh from Copenhagen, with a box full of slides and descriptive notes, gave an instructive paper on the trend of European hospital architecture. Schmidt described how a great charity hospital should be built, having in mind the Cook County hospital, Chicago, at present under construction.

Lamoreaux described the multi-storied municipal hospital building in Minneapolis. Hornsby's talk on the conversion of old-fashioned houses into small hospitals was unique and ingenious. Fuld, in a paper read by proxy, told how hospital employees are selected in New York, with especial reference to

*See next issue.

the civil service requirement. This paper provoked a fine discussion.

Norton, of Baltimore, scathed the existing municipal hospitals of America, barring only three or four. It was a fine paper, and deserving of wide publicity, the reference he might have made lacking only the pleasing contrast afforded by the German municipal and State supported hospitals.

Dr. H. J. Hall, of Marblehead, Massachusetts, gave an illuminating paper on hospital and asylum workshops and some possibilities for handicapped labor. Dr. Hall has inaugurated this movement in his institution at Marblehead, which is now self-supporting. The Massachusetts General Hospital proposes to adopt similar methods, and we predict that in a few years hospitals throughout the continent will undertake this magnificent work of finding out what the handicapped man can do and loves to do, and set him at it.

There are too many unhandicapped, as well as handicapped, misfits.

Dr. Herbert C. Cole, of Bogalusa, La., read a good paper, and showed the plan of a well-laid-out hospital.

Original Contributions

THE CARE OF THE SICK IN HOMES OF MODERATE MEANS*

BY MISS CHARLOTTE A. AIKENS.

A well-known sociologist has stated that the people of moderate means number five-sixths of the population in the United States and Canada. The problem of the care of these people in sickness in their homes is not a new one. Every physician with even a year's experience in private practice is perfectly familiar with it. Ever since we have known the value of efficient bedside care in sickness we have longed and hoped that its benefits might in some way be brought within reach of all the sick who really need skilled care. By a perfectly natural process, and as a means of securing work for graduate nurses, so-called registries or directories, or employment bureaus for graduate nurses, came into existence. These meet the needs in homes of well-to-do people who can afford to pay regular rates for skilled nursing. By means of private philanthropy, visiting nurse organizations have been established for the very poor, and those in the class immediately above them, who can pay a little for such assistance. But from the beginning of trained nursing there has been the great gap between these two organized efforts—always the lack of provision where continuous care was needed, for this great middle class, those who do not want charity, but who are unable to pay the twenty-one, or twenty-five, or thirty dollars a week for the graduate nurse.

Within the last decade the problem has been rendered much more acute by the steady march of inhabitants from rural districts and small towns to the cities—a movement that shows no signs of abating. One result of this redistribution of population has been that millions of mechanics, clerks, stenographers, bookkeepers, tradesmen and laborers of all kinds, have been separated by distance from those on whom they might naturally call for help in sickness—mothers, sisters, relatives, and real

*Read before the Wayne County Medical Society, Detroit, May, 1913.

neighbors, and they find themselves in a city with no substitute but hired care of some kind. The expansion of business and manufacturing interests has drawn from service in homes thousands of women who a generation ago would have been available for such emergencies. While these vast changes have been going on, other changes affecting the situation have taken place also. Fifteen or twenty years ago a nurse who graduated could go out from the hospital, free to nurse whom she would, and she might charge ten, twelve, fifteen, or twenty dollars a week for it. She with the doctor and the family decided that matter. Now the young nurse who graduates is confronted by rules of alumna associations, rules of directories, fixed fees, and rigid limitations on all sides. Whatever she individually might wish to do toward meeting the need in middle class homes, the average graduate nurse of to-day is not free to do it without opposition. She did not make the conditions which confront her; they were made for her, and she naturally follows the course of least resistance and accepts what she, *alone,* is powerless to change. In most other professions the young graduate with his experience with the world yet to be gained, and his record yet to be made, is content to begin with a small salary and work up, increasing his charges as his reputation and experience warrant. And this is true in most departments of nursing. The nurse who goes into institutional work does not command, on graduation, the highest price, and the same is true of visiting nurses and social service nurses of all classes. It is only in private nursing that we find the dead level—good, medium, and indifferent—experienced and inexperienced—all charging the same price. The dilemma which the young graduate of to-day finds herself in is clearly shown in a case—not in Detroit—which was brought to my attention recently, when a graduate nurse was expelled from her alumna association and registry for lowering her price for some family in which she had nursed.

The result of this policy has been that two-thirds of the field of nursing has been left uncultivated and unoccupied so far as hospital graduates are concerned. They have complained about the over-production of nurses and about the competition of less skilled nurses when they were idle for any length of time, but every student of social conditions knows that we are a long way

from having enough nurses to nurse all the people who need skilled nurses. The trouble has been in our lack of civic or community organization, and lack of facilities for distributing the skilled nurses, so that they could get to those who really needed them. The immediate task before us is not how we may limit the production of nurses, but how we may better distribute them. The schools which trained the nurses, the physicians, and the public have expected that somehow the graduate nurses themselves would work out this problem, but they never can and they never will, for the problem is too vast for any one class of workers to handle alone. Any solution of this problem coming from any one body of workers is apt to be tinged with self-interest, and that alone is a sufficient handicap to defeat it. Neither can the visiting nurse associations handle this problem, because, for one thing, the task the visiting nurses have on hand is big enough already, and for another reason, that visiting nursing, in the minds of most people, stands for charity, and the people who most need efficient nursing in middle class homes do not want charity, will not ask for it, and would feel under reproach if it were offered. Graduate nurses and registries can help, and visiting nurses can help, but neither alone can ever successfully deal with this problem—which is by all odds the most important problem in present-day nursing, though there are other problems which are getting a good deal more attention.

The result of the abandonment of this middle class field by graduate nurses in general has affected the hospital situation in at least two ways. First, it has driven hundreds of people every year, in Detroit and elsewhere, to apply for hospital accommodation who could have as safely and efficiently been cared for at home, if they could have found a nurse who would fit into the needs of the home. This increased demand on hospitals has driven them to take in more and more nurse candidates to train, who, in turn, have gone out to follow the straight line marked out for them and who have competed with each other for work. The increased demand has also driven hospitals into enormous expenditures for new buildings and maintenance, which in turn have required an enormous amount of new material to be trained as nurses if the patients were to have intelligent care. Thus we might follow this circle of influence around and find it acting

and reacting adversely on hospitals, on nurses, and on the great human public whom we are expected to serve. The past decade has seen a degree of activity in hospital building which has been unparalleled in the history of the world. Unprecedented capital has been freely poured out in the attempt to meet the demand for hospital accommodation. In New York City alone, in the year 1912, eleven millions of dollars were put into new hospital buildings and extensions. In Boston also in the last few years almost as many millions have been expended for hospital buildings, and yet the problem of nursing in middle class homes is just as acute there as ever—and just as acute as it is in Detroit. We can go on building hospitals at the same rate till the end of the century and yet not solve this problem—for the simple reason that it is primarily a *home* problem, and must be worked out in the *home* and for the *home*—not taken out of the home and institutionalized. One reason why we have not made progress in this matter is that most of those who have worked at it have been afflicted with what Dr. Richard Cabot has termed blindness to foregrounds, or blindness to backgrounds, or have been as a horse in blinders, seeing only the thing which was directly in front, and not seeing what was on either side so close to the problem as to be practically inseparable. The care of the sick as a whole has yet to be approached, in Michigan at least, in a statesmanlike manner, with a determination to see all sides of the situation in their relation to each other. If we could have a commission to study the whole question of the care of the sick of a given community—a commission with a statesman's vision—might we not find the task laid out for us in about the following manner: *First,* a survey of the field, to get an idea of the extent of the problem and the existing resources—their scope, location, and limitations. *Second,* the development of an adequate dispensary system in which each section of the city was provided for—a dispensary system which had for its main objects the prevention of disease, the detection of disease in its incipiency; the keeping, so far as possible, outpatients from becoming inpatients, or ambulant patients becoming bed-patients; and with efficiency tests applied to the work, at every step of the way. *Third,* provision for efficient care at home (which is the place in which sickness is usually first dealt with) of all such cases as require

bedside nursing, yet whose presence does not endanger others, and which require no very expensive apparatus for scientific treatment. *Fourth,* the provision of hospital accommodation sufficient for such patients as cannot be handled in an efficient manner in either dispensary or home. *Fifth,* the effecting of a system of co-operation in administration of all agencies at work caring for the sick of the community.

Such a system as I have tried to outline is simply the kind of system which any business firm and any well-organized hospital applies to its own affairs. A business firm carefully studies the effect of other enterprises on its own development. A business firm studies how to utilize to the fullest extent its by-products, so that its plant may reap the maximum benefits from its working. A business firm constantly studies new uses for its products and endeavors to create a demand for them. It does not put a $100 a week man on a ten-dollar job. It fits the skill of the man to the job he is required to do. A hospital doesn't put a valuable, highly skilled nurse to wash dishes or sweep corridors—not because these domestic occupations are not perfectly honorable, but that her skill is worth too much to the institution to make it good business to let her spend her time in such work. We must come to the place where we will apply the same business sense to our community problems. The need in middle class homes is a legitimate one and should be studied and met in a business-like way. We have for years tried to separate the patient from the home in our planning for him, but in the majority of cases he refuses to be separated—or she refuses, for the problem is most acute when the mother of the family is the patient. We shall never make progress until we consider the care of the patient in the home, and the care of the home in sickness, as *two sides of one and the same problem.* The mother with little children will not willingly leave those little children and her home to go to the hospital, unless the illness be of a quite serious nature. She rightly asks to be considered in connection with her home and her little ones, and cared for there if possible. She offers all she can afford for the kind of worker who will care for her in her home, and it should be the business of some organization to see that she gets what she asks. We have tried to offer her a commodity at three and a half or four dollars

a day, when what she wanted was a different commodity at one and a half or two dollars a day—which is just about as sensible as offering a farmer a valuable race horse to do his work when he needed a general-purpose animal.

The only solution with which we can ever be content is a solution which fits the nurse to the requirements of the case, a system which conserves the home, which does justice to each class of workers and preserves self-respect all around. The present age demands both economy and efficiency in nursing as in other occupations. Economy without efficiency spells parsimony, and is not true economy. Efficiency without economy means waste, which is everywhere to be condemned. Economy and efficiency in hospital management demand that economy and efficiency in home care go hand in hand with it—the hospital doing what the home cannot do efficiently and economically. Just as we have seen the pendulum swing in medical treatment from the extreme methods in vogue a score of years ago, and simple natural remedies and methods take their place, so we are going to see the emphasis shift in nursing matters, and the care of the home in sickness command the attention its importance demands—for homes are important institutions. We have made considerable progress in training nurses in the last quarter of a century, but we have been dismal failures in fitting nurses for this important work in middle class homes. Within the last decade we have seen the evolution of the social service nurse—the nurse with some degree of social training and with the social vision. We have seen the evolution of the school nurse and the welfare nurses of various kinds. We are going to see the evolution of a new type of nurse, or of a nurse with a new vision—the vision of the middle class home as a field for social service, and of her rightful place in that field. She will not try to occupy it all, but she will work in it—if we give her a chance, and if during her training we give her a vision of the needs and the possibilities in that field, and if we provide the machinery whereby she may the more easily reach those in that field who need her care. We have heard a lot in recent years about *educational standards and educational ideals*. We are going to hear more in the future about standards of service. We shall, perhaps, add a course in "the humanities" to our curriculum. Even if we have to teach

less about chemistry and psychology and similar subjects now found in the nurse's training course, we are going to try to get time during the three years' training course to tell nurses a little more about human needs and how they should be met. However high our educational standards and ideals may be, we can never claim to have reached a very high stage of civilization while we have groups of skilled workers idle here and there in our cities—because no man hath hired them—at the price they ask—and hidden away in middle class homes on side streets and avenues all over our city are sick men, women and children who sorely need the skilled care they are able to give, but no machinery available whereby the workers we have labored to train can be brought to their bedsides.

We have haggled a lot about this problem. Everybody concerned has criticized somebody else, and everybody has appeared more or less worried about conditions, but some day soon we are going to be sensible and get together, and, beginning at the very roots of the problem, work together, till we reach a satisfactory solution. If the signs of the times show anything at all, they indicate very clearly that in future the bulk of the private nursing in homes is going to be done by women who have *not* expended three years in learning to do a lot of things they will never have a chance to do in homes; the bulk of it will be done by women who combine some measure of assistance in household duties with the care of the invalid. The household nurse is destined to take the place of the private in the soldiers' ranks, with graduate nurses as officers and working directors in the service. The antagonism between the grades of nurses will cease when each is fitted into the place she can best fill. All household nurses are not Sarah Gamps—far from it. Neither are they all possessed of that serene self-satisfaction born of ignorance of which many graduates accuse them. My own observations lead me to believe that the grade of women now going into household nursing is considerably higher than was the case ten or twelve years ago. The high cost of living has forced a lot of excellent women who ten years ago would have entered a hospital to train, to go into this field of nursing in middle class homes. Within the past few months from a little group or class of fifty women or thereabouts, in the church to which I belong,

three of them have gone into household nursing—urged into it in every case by a doctor who had observed them in the care of some relative or friend. I am bound to say that I commend the doctor's judgment of the candidate in all three cases. All are excellent, capable women. One would be accepted in any training school in Michigan which needed nurses. The others would only be debarred by the age limit of thirty-five years. There should be no quarrel between these household nurses and the product of our schools. Many of the difficulties of the household nurses, and the difficulties between the two grades of nurses exist because of the lack of any responsible, impartial organization to appeal to—an organization which would work out the adjustment necessary, and make the one grade supplement the other. We can do this, if we work together, and we can do it so that each grade of worker will receive the remuneration to which her skill justly entitles her.

It was neither a doctor nor a nurse, but a preacher, who first worked out a system for training nurses—Fliedner, of Kaiserwerth, and to whom Florence Nightingale went to learn what experience had taught about the care of the sick. It was a business man—William Rathbone, of Liverpool—who thought out and started the system of visiting nursing of which our present-day system is a development. Similarly, in our own day, it is neither a doctor, nor nurse, nor hospital superintendent, but a business man, who has brought to us the first practical, workable plan for meeting the nursing needs of a community in middle class homes efficiently, economically, and with justice to all classes of workers. For years Richards Bradley, of Boston, has worked at this definite problem, patiently and laboriously, as a scientist might search in his laboratory for a new germ or a new serum—trying first this method and then that—and applying efficiency tests every step of the way. What William Rathbone has done for visiting nursing, and Dr. Richard Cabot has done in leading the way in hospital social service, he is doing in a quiet way for the improvement and standardization of nursing in middle class homes. The methods which have been worked out in several places in New England, and which are being studied now by many communities in different parts of the country, are, in brief, as follows: First an organization of citizens—an organiza-

tion similar to a hospital board, which is committed to the definite task of supplying middle class homes during sickness with the kind of help needed—whether graduate nurses, untrained nurses, or simply domestic assistance—an organization whose motto is "This one thing I do." The objects as stated are twofold—the care of sickness in the home and the care of the home during sickness—which in most middle class homes are inseparable. For the working out of these objects a central clearing house or office is established, with a graduate nurse in charge, and a field nurse for supervisory and educational work. A corps of workers of different grades are on call—and these work under the supervision of a graduate nurse, just as do pupil nurses in a hospital. Each of these workers has had her character and credentials enquired into, and her ability tested, and each has been given some preliminary instruction in bedside nursing before she is sent out. She is also instructed as to what she is to do and whom she is to appeal to in case of difficulty or emergency. When a call comes it is the business of the head nurse in charge of the office to determine, in conference with the physician or family, whether a graduate nurse is needed, and for how long she is likely to be needed, or whether an untrained or partly trained nurse who will assist with the care of the home will more fully meet the needs of the case. If a skilled graduate nurse is needed for a few days to tide over a crisis, or to administer special treatment, she is sent for as long as is necessary, and replaced by a less skilled nurse when such will fully meet the needs—the untrained worker always being under the general supervision of the organization, and supplemented when necessary by the skilled nurse, the graduate nurse receiving her regular rates while she is on the case. In many cases the mother, with a little instruction, can manage the case without difficulty if she can secure some assistance with the regular household duties. It is the business of the household nursing office to find such help for her. Experience has proven that in most communities there are plenty of women who can leave their homes for a few days, or for a few hours each day, to assist during sickness in this way who would neither go out to regular domestic service nor undertake nursing. They are, however, anxious to add a little to the family income, and they meet a community

need in this way. Experience has also shown that there are many families on whom sickness comes suddenly who cannot, at the time, meet the expense of a graduate nurse, and would never think of sending to a registry for one, but who could meet the expense for a short period, if given time, or who have friends or church or lodge connection or shop associates who will "chip in" and help to pay for a skilled nurse when the necessity of it is explained, and when they know that a less expensive nurse will be provided as soon as the critical stage is passed. While the household nursing office is organized on a business basis and not to dispense charity, it has proven effectual in stirring a lot of other organizations up to get the money where charity is needed, while it confines itself to the doing of the real work. Five-sixths of the work done by the offices which have been established has been paid for in full by the people who received the service. In Brattleboro, Vermont, where the method was first worked out, the cost for caring for twenty-five maternity cases taken in routine, in 1911, which were averaged, was about $12 a week. This included pre-natal instruction to the mother, the services of a graduate nurse at the birth, and a household nurse for continuous care of patient and home. The only cost which the community has to meet is the cost of administering the office work, which, in a city like Detroit, would amount probably to between $2,000 and $3,000 a year. The plan seems capable of indefinite expansion and has proven successful both in large and small communities. Appeals were brought to my attention while this paper was being prepared in which two communities which are organizing their home care for the sick offered, respectively, $1,200 and $1,500 a year to a nurse to take charge of the executive work and instruction connected with it, and there is no doubt that the executive work alone is going to provide employment for a large force of graduate nurses, as the work develops.

The result of the practical working of this plan for organized home care for the sick, of moderate means, has been to bring the graduate nurse, who receives her regular rates, to hundreds of families each year for a longer or shorter time—families who would, without the advice and assistance of the household nursing office, never have thought of employing one. It has given to untrained and partly trained nurses the assistance and direction

in their work which many of them sincerely desire and all of them need, and the assurance of a sympathetic organization back of them to help them in any difficult situation in which they may find themselves. It has given to physicians and citizens a responsible representative organization to appeal to in time of difficulty. It has given to hundreds of honest, capable women an opportunity to do their part in promoting social well-being, without any necessity of posing as something more or different than they really are. It has afforded some relief to busy overcrowded hospitals in lessening the demand and in letting patients go home earlier, because it was easy to find someone to give the degree of care in the home which they required in convalescence.

The development of such a system is so closely related to the economical and efficient management of hospitals that it cannot much longer be disregarded. It must come as a logical development in the progress toward the highest efficiency. We are going to see the unwisdom of spending two dollars and a quarter or a half a day, not including capital cost, to care for people who could have been cared for equally well in the home for a dollar or half a dollar a day less, had we any organized agency for giving the kind of care needed. The American Hospital Association has worked at this problem, by spells, for five years, and has expended around twelve hundred dollars and a lot of time and study in standardizing nurse training. It has been asked to assist in this work by fixing a standard of instruction which should be given to household nurses. It has also been under the necessity this year of completing its own special task of standardizing the instruction which might properly be attempted in small and special hospitals—those institutions which have not a sufficient variety of experience to offer to pupil nurses to make it worth while to remain three years, or even two, but which are forced by stern necessity to give some degree of instruction in order to give their patients intelligent care. Since graduate nurses cannot be had in sufficient number for the routine work in such institutions, they are obliged to pick the best help the community affords and give such training as is possible, and the community has shown itself very ready to receive and employ these less expensively trained nurses. Dr. Thomas Howell, of New York Hospital, when in the Worcester City Hospital, cal-

culated for one year after another the cost of maintaining and educating a pupil nurse for three years. He found that the average cost of carrying a nurse through from her entrance to the school to her graduation was around $1,100, or a little over a dollar a day each day for the three years of training. To carry a nurse through such a course is an expensive proposition all around. It should teach us to study how we may utilize her skill to the fullest extent.

The small and special institutions can easily give the foundation studies in a nursing course, such as general nursing technique, materia medica, bacteriology, hygiene, and dietetics—just the instruction which the nurse can best use in homes. What they cannot give is the varied clinical experience, which the nurse can and does get in the field in course of time. After prolonged study and investigation of the entire field in large and small communities from the Atlantic to the Pacific, the committee appointed by the American Hospital Association this year has agreed that at least two grades of nurses are an absolute necessity, and for the present any efficient system of organized home care for the sick must include three grades—registered or graduate nurses with a full general training, certified nurses with at least one year of training, and household nurses who combine household assistance with the care of the sick. It believes that, instead of leaving this great middle class field to commercial organizations and correspondence school nurses, to be exploited for the pecuniary benefit of the promoters of such organizations, the large number of small and special hospitals should try to meet this need, while a responsible civic organization should assume the responsibility for the distribution and supervision of the workers according to standards agreed on by hospital people themselves. The committee asks the hospitals giving full general training to not drop the young graduate as soon as her diploma is signed, but to try to widen her opportunities and to help her find her right place in the great field which she has entered. It believes that it will pay the hospitals in several ways to do this. It believes that with the responsible local organization described the interests of all can be conserved. It believes that co-ordination is better than competition, and that doctors, who need such assistance, can be powerful factors in bringing about this co-

operation and co-ordination and efficiency in service so much to be desired.

When we face the problem squarely it resolves itself into a study of the legitimate requirements of each individual home in sickness in each community, and the organizing of a co-operative service to meet those needs. If there is a better way than the one I have tried to describe, the committee referred to will be glad to discover it. If there isn't a better way, shall we try to follow the plan which has proven workable and which seems to have economy, efficiency, justice and business sense to commend it?

THE BARTLETT LIGHT IN THE SHIELDS EMERGENCY HOSPITAL

DR. N. A. POWELL.

THE old order changeth in lighting systems as in all things else. Installations made three years ago may already be *passe,* while those now but five years in use may be archaic.

When the responsibility of working out the plan and the equipment of a new hospital department fell to the lot of the writer, and when the question of an operating room light came up, various plans were critically examined. Nearly fifty operating rooms were visited after nightfall, and the good nature of the nurses in charge was, I fear at times, rather severely taxed. They showed a forgiving spirit in pointing out to me wherein changes for the better could be made. Then one night at dinner Dr. W. J. Mayo mentioned to me the experiment of Dr. Willard Bartlett in focusing automobile headlights on a field of operation. This recalled an experience ten years ago which illustrated the ingenuity and resourcefulness of an Ontario country doctor.

Reaching a village at midnight I found a man desperately ill with appendicitis in a house but dimly lighted. I spoke of the added risk of a delay till morning and of the handicap of operating under existing conditions. The good friend who had sent for me, Dr. Charles T. Noble, of Sutton West, said, "Start your sterilizer, the light will be all right." When everything was ready he went to the kitchen door and said, "Come in, boys," and in marched six farmers, each carrying a lamp and reflector.

They ranged themselves at safe distances around the table, focused the illumination on the field isolated by towels and made my part an easy one.

I have a haunting suspicion that credit for the result obtained in this case was most unfairly divided, and that my share was disproportionately large.

Following up Dr. Mayo's suggestion, I obtained a perfected Bartlett light through the Scanlan-Morris Co., of Madison, Wis., and its general features are shown in the accompanying photograph. For a detailed description those who are interested may consult papers by the originator in the *Annals of Surgery* for January, 1913, and in the *Jour. A. M. A.* for June 14th, 1913.

The system seems well adapted to the needs of an emergency

hospital and should as well add a new element of safety to the performance of such operations as a Wertheim hysterectomy, a common duct exploration or a mastoid section.



The Bartlett Light, recently Installed in The Shields Emergency Hospital, Toronto.

One other incidental advantage will be making details, wholly unrecognizable under conditions commonly encountered in surgical clinics, quite clear to visitors on the observation stand.

Society Proceedings

BRITISH HOSPITALS ASSOCIATION ANNUAL CONFERENCE AT OXFORD

THE fourth annual conference of the British Hospitals Association was opened in the Examination Schools, Oxford, on June 26th. The Regius Professor of Medicine (Sir William Osler, Bart.) presided, and was supported by the following members of the Council of the Association: Dr. D. J. Mackintosh (Glasgow) (Chairman), Sir Henry Burdett, K.C.B., K.C.V.O., Mr. Stewart Johnson (London) (Hon. Treasurer), Mr. C. W. Thies and Mr. Alexander Hayes (London) (Hon. Secretaries), Mr. J. C. Buchanan (London), the Rev. J. M. Campbell (Dumfries), Mr. W. G. Carnt (Manchester), Mr. H. J. Collins (Birmingham), the Rev. G. B. Cronshaw (Oxford), Mr. H. W. Deacon (Liverpool), and Mr. E. Forster (Derby). Those who also signified their intention of being present were: Dr. Waters, Dr. Brooks (Oxford), W. Alvey (Charing Cross Hospital), E. L. Blake (Oldham), Rev. E. H. Bouth (Cheltenham), J. C. Barnes (Derby), J. J. Burnet (Glasgow), A. W. Bryant (Cheltenham), A. E. Batchelor (Warneford Hospital), C. S. Bisbee (Northampton), F. J. Bray (Leeds), J. Cooper (Manchester), G. A. Cardew (Leeds), W. Dewar (Glasgow), L. H. M. Dick (Nurses' Insurance Society), J. Elliott (Chester), A. T. Flagg (South Shields), Miss A. C. Freeman (Women's Hospital, N.W.), A. H. Franklin (Royal Waterloo Hospital, S.E.), W. A. Fitzgerald (Chester), R. B. Gwydir (Swansea), W. Gray (Glasgow), T. E. Graveby (Wellingborough), A. Griffiths (East Suffolk Hospital), W. H. Harper, W. H. Head, H. H. Jennings (Women's Hospital, Chelsea, S.W.), E. C. Kemp (Charity Organization Society, London), Sir R. Lord (Newcastle), H. D. W. Lewis (Cardiff), C. Lapton (Leeds), G. E. Maw (Northampton), W. J. Morton (Mount Vernon), J. Macfarlane (Glasgow), D. MacGregor (Glasgow), F. H. Moore (Liverpool), J. Macpherson (Edinburgh), E. Morgan (Royal National Hospital for Consumption, Ventnor), A. Naldrett (Liverpool), J. S. Neil (Wolverhampton), H. S. Nason, R. A. Owthwaite (Hampstead General Hospital), J. Oldfield (Lady Margaret Hospital), F. Oliver (Ashton-under-Lyne), P. J. de

Paravicini (Windsor), H. T. E. Peake (Newbury), W. A. N. Price (General Hospital, Herefordshire), E. Robbins, N. Raw, G. Ruddle (Salford), J. C. Richardson, J. P. Somers (Bushey Heath), F. Smith (Leamington), J. E. Smith (Bristol), G. F. Sheppard (Royal Free Hospital, N.W.), T. C. Shingler (Llandudno), I. H. Swanton (Kensington), J. H. Shaw (Southport), C. M. Smith (Ramsgate), C. Tyler (Stockport), H. Toulmin (St. Albans), Miss H. Todd (National Health Insurance Commission), G. Thomas (Newport), M. Thorn (Glasgow), E. M. B. Vaughan (Cardiff), J. Wood (Burton-on-Trent), S. E. Wilkins (Royal Bucks Hospital), J. J. Webb (Tunbridge Wells), G. Watts (City of London Hospital for Diseases of the Chest), and K. D. Young (London).

WELCOME FROM CITY AND UNIVERSITY.

A hearty welcome was accorded to the visitors by the Mayor and the Vice-Chancellor.

The Mayor said it was his happy privilege that morning to offer to them a very cordial and hearty welcome to Oxford. He had little knowledge of the profession itself, but as long as they had Sir William Osler managing the medical ship in Oxford he was sure that everything possible would be done to mitigate suffering and, as far as possible, to suppress the ravages by those diseases which were so prevalent amongst us. He hoped that their stay would be not only instructive but pleasant, and he hoped they would take away memories of Oxford on which they would look back with very much pleasure. (Applause.)

The Vice-Chancellor said he had only to echo, on behalf of the university, what the Mayor had already said on behalf of the citizens. Theirs was a work in which as on so many occasions the city and university were heartily in co-operation. The importance of the work everyone must recognize, and an instance showing that its importance was increasing was provided in the National Insurance Act. He was glad also to see that they were to visit the Radcliffe Infirmary. He hoped that they, with their great experience, would be able to say of their new buildings that they were thoroughly up-to-date and were as satisfactory as possible. He trusted their visit to Oxford would not only be profitable, as it was sure to be, but that they would find that Oxford

was a pleasant place in which to spend any spare time that they might have. (Applause.)

A vote of thanks was passed to the Mayor and Vice-Chancellor upon the motion of the Chairman.

PRESIDENTIAL ADDRESS.

Sir William Osler then delivered the presidential address. He congratulated the association on its organization, on the good work it had done, and on the very good work it would, no doubt, do in the future. It was exceedingly kind of them to have asked him to be their president for the ensuing year. He was singularly deficient in all of the necessary qualifications for such an office. There was probably no one, who had been for so long intimately associated with hospitals, who really knew less about their administration. He had known the patients, the house-physicians, the nurses, and those in charge intimately, and he had worried the lives out of them for several generations, but he had persistently avoided knowing anything about hospital administration. If the patients were comfortable, if the beds were clean, if the nurses were happy, and if the house physicians were well housed and well fed, he knew that the administration was sound. He had been intimately associated with the hospital systems which obtained in America, Canada and England. One of the special features in this country was the admirable quality of the smaller hospitals, and it was more particularly on the work of the County Hospitals that he wished to speak that morning. An extraordinary amount of interest was aroused in the hospital in the district in which it was situate. He quoted as an instance the interest in the city and county in the Radcliffe Infirmary. Prominent citizens, and persons in the county, were willing to spend a great deal of time in the working of these hospitals. They were admirably managed, and the arrangements were excellent, so far as nursing, the care of patients and the up-to-date character of operating rooms was concerned. They had fallen on troublesome days, and were full of worries and anxieties as managers at the present time. That was good for them. He hoped their worries might be increased by what he was going to tell them that morning. (Laughter.) There was nothing like being thoroughly chastened when the rod was upon them. (Laughter.) There were four points with which he wanted to deal. The first

was the debatable one of the voluntary system. His advice to them on that point was very brief, but very direct—Give it up; cut it off—it was antiquated, it was out of date, and it was not going to continue. They might as well make up their minds that they had got to accept the principle in their general hospitals of taking pay. It answered very admirably elsewhere. They had to take money from the insured patient, and there was no reason why they should not take it from other patients, who could pay them. There was one striking contrast between the hospitals in this country and Canada and the United States. Here they did everything for the poor, who were therefore rich in hospital care and hospital treatment, but they did nothing whatever for the poor rich, who were the most neglected people in the country. (Hear, hear.) There were plenty of nursing homes that were admirable and up-to-date, but there were a good many that were not, and there was not a nursing home in the country that could take care of a patient as well as a general hospital. He would like to see introduced into this country private pavilions attached to every hospital. There was a statement current that private wards in general hospitals did not pay, but he knew better than that, and that they could be made to pay very well. His second point dealt with clinical and pathological treatment. They might just as well know the truth that, so far as their clinical and pathological arrangements were concerned, in this country they were hopelessly behind the times. They had to reform that, and to rearrange their ideas. Many of them were pig-headed, obstinate and hopelessly ignorant as to this question. (Laughter.) They knew that upon chemical and bacteriological research, modern medicine was built, and they could not have proper treatment of their patients, or cases properly investigated unless they had good chemical, bacteriological and pathological laboratories. In the great majority of county hospitals, these things did not exist, and they should make provision to have them at the earliest date. They cost money, but that was their business. They were there to provide means for the best possible treatment of the patient, and they could not do that without bacteriological laboratories. His third point was a somewhat delicate one, because it dealt with the medical profession. Medicine was a very progressive science, and it took a large part of a

man's time if he was dealing with the study of internal diseases. They should try to have connected with every hospital a student who was working at those problems, not as a purely medical practitioner, but as a consultant. About 100 years ago, nearly every county town in England had its pure physician. It was a curious piece of history how it was that the conditions had changed, so that now there were very few county towns with hospital physicians who were pure physicians, who only saw cases in consultation, or only saw purely medical cases. One reason was that they had too many on the medical staff of a hospital as physicians. They very often had two or three where one would do. He thought it was a plan that would work very much better if in a hospital with only 50 or 60 medical beds they should have one physician, and make him a pure consultant—that he should not be allowed to undertake general practice, but that he should be paid a fixed stipend by the hospital to enable him to devote a large part of his time to medical investigation and the care of the patients. His fourth point dealt with the importance of utilizing county hospitals for purposes of instruction. In the old days the county hospitals were used for medical students. Nearly every hospital had five or six or a dozen medical students, who attended during the long vacation. It was now the rarest possible thing to see a medical student in a county hospital. There was one work they could do which was of the greatest importance. Not only should the county hospital be the consulting body for doctors throughout the country, but it should be the centre to which they came for systematic instruction. No body of men needed more persistent brain-dusting than doctors. The profession of medicine was progressing at such a rate that in five or six years a man's knowledge was rusty, and it was a most important thing for the public that the average doctor should keep up-to-date. One way in which he could keep himself thoroughly informed was by having post-graduate courses in connection with the county hospitals. He hoped that the British Committee, which had this post-graduate instruction in hand, would present this year for each county hospital a scheme dealing with post-graduate instruction, and it could be easily and satisfactorily arranged. He hoped that by next Autumn they would have a post-graduate week at the Radcliffe Infirmary. He was sure throughout the

country such a course would be the means of providing valuable information to the doctors in each community, and it would help to link up the doctors more closely with the hospital, which would be a mutual benefit. The plan had worked admirably on the Continent. It was not expensive, and the cost would be readily met by the profession of the county. There were two points he wished to particularly impress upon them—the necessity for more scientific work in the way of clinical and pathological investigation, and the possibility of making every hospital, over which they had control, a centre for the whole profession. The linking up of the hospitals under the Insurance Scheme would promote that very much. They should make every panel doctor feel that the hospital was the place to which he would go for advice and for aid in a special emergency. If they alienated the general hospitals from the panel doctor they had only one alternative, and that was State service. They had to work their hospitals with the panel system, or else the panel system would have their municipal scheme, and they would have two rival institutions in each place—the municipal service and the county hospital. (Applause.)

THE INSURANCE ACT—ITS EFFECT UPON HOSPITALS.

The morning session was devoted to the consideration of the National Insurance Act and its effects upon hospitals.

Dr. Mackintosh opened the discussion, and prefaced his remarks with a few comments on the presidential address. He thought Sir William was correct up to a point when he said the sooner the voluntary principle was done away with the better, but they had to find out whether the voluntary principle had been a failure. If it were a failure, they must not nibble at it, but get rid of it straight away. There were only two clauses under the Insurance Act which dealt with hospitals. The first was Clause 12, in which it was said by making arrangements hospitals might be paid some of the money which went to the dependents of the insured. They must make the arrangement. If that were all they were to get from the State or the approved societies, it would not keep the hospital doors open for any time. They were at the parting of the ways. They must either go to the State, or support the voluntary system more enthusiastically than in the past. Let them take for instance the question of the

working-man contributor. His experience at the Western Infirmary, Glasgow, was that working-men had not ceased to contribute because the Insurance Act had been working for six months. Now, they could not have it both ways. The working-man asked when the Insurance Act came into force what part of his medical benefit was going to be taken by the hospital. The principle he had gone upon was they took none of the sickness benefit. This benefit went to the sick man, and they had no bargain and they had signed no agreement with any Government officials. He thought it would be unfortunate, just as the new Act was being amended, that they should come to any conclusion at that meeting until the whole thing had been carefully considered by the Council. So long as the industrial class supported the hospitals, as they had done in the past, why should they expect them to give hospitals any part of the sickness benefit at all? Certainly the Act was never drafted with that intention. The sickness benefit was to go to the sick man, or to his dependents when he was sick, and he thought the meaning was that when he came out of hospital that sickness benefit might go towards helping him to another start in life. These amounts would not keep the voluntary hospitals open. They should make no agreement with any Government body or approved society to take any sum until they saw how far it would adequately keep their hospitals going. So long as the voluntary system was successful, and could be maintained at its present high standard, he thought they should stick to it. Let them wait and see the effect of a year's working of the Insurance Act, and not act too hurriedly when it had only been in operation for six months. There was a proposal which had been sent out in connection with Clause 12, whereby approved societies would be allowed to make a payment per week practically for work done. That was as near State control as he could conceive. Approved societies were at liberty to give donations and subscriptions like any other society or individual, but to sign an agreement with an approved society that they should take in their patients for so much per week and give a receipt for them was simply handing it over right away to the State. They could not declare any policy that day, but they would be glad to have the views of delegates from different parts of the country. (Applause.)

The chairman remarked that in Germany a large proportion of hospital patients paid for their treatment through their insurance societies.

Sir Henry Burdett said he thought Dr. Mackintosh had entirely misapprehended the first point in the presidential address. He thought what Sir William meant was that they should give up the present system, which did not provide for all classes of the community who needed hospital care. He was of opinion that national insurance had come to stay. The unpopularity of national insurance and its imperilled condition to-day was due entirely to the fact that a complicated revolution in our social system, such as that which national insurance necessarily meant, ought never to have been attempted until all the wisest heads and all the most experienced brains had been consulted, and until the system had been carefully thought out and organized by the best of our administrators, so that when it came into force it would not be an apple of Sodom, but a real, genuine fruit which would yield the comfort, the support, the help, and supply the urgent necessities by diminishing the suffering of the poorer members of our people, and especially the working population. They were tired of the absence of statesmanship in high places. Dr. Mackintosh had advised them to wait. It was all very well to wait, but they had also to prepare. More beds would have to be forthcoming in hospitals, and the problem was—how were those beds to be supplied? In London they would certainly want an additional 5,000 in the next two years.

The Chairman: Where are the people sleeping now?

Sir Henry Burdett: They are not in hospitals.

Why should they be? They will require treatment.

Sir Henry Burdett, continuing, said the Insurance Act swept in all the people who were ill. There was a great system of recruiting, and the tendency would be, wherever there were severe cases, to put them in hospitals. If national insurance was to do any good, it would have to seek out people who required in-patient treatment, and see that they got it as quickly as possible. It was a great hardship on hospitals, but the one solid financial backing that the Insurance Act had, from the actuary's point of view, was the hospital provision. It was this that had astonished the world, and made them say. "Has this nation of shopkeepers

lost their business sense?'' Liverpool and Manchester had set a good example in making grants to the hospitals. It seemed to him that the hospitals ought to be met, so far as increased accommodation for insured patients was concerned, by the Government agreeing to lend to hospitals the money that was required to erect the necessary pavilions to contain the additional beds, needed for insured persons, wherever that need might arise, on these terms—a loan at 3 per cent., with a sinking fund at 1 per cent., so that the loan should be redeemable, and the charges on that loan should be the first charge on the receipts for the maintenance of the patients contained in the new pavilions. That was a point that must be met. They had to educate the public to agree to extend the pay-system, and to bring pressure to bear on the Government to provide money on the Liverpool principle for the maintenance of buildings, and to see how and to what extent they could get, on the German plan, the pro rata repayment of the actual cost of maintaining insured persons in the voluntary hospitals to the managers of those hospitals. To say that if they had a system of loans or payments on account of insured persons, they must get State control was mere bogey, and he denied it altogether. Without aid from the hospitals the national insurance system could not continue to exist as a business undertaking, and would be bankrupt in three years. Consequently, any claim of the Commissioners to be represented on the management could not be maintained on any just or reasonable ground. (Applause.)

Mr. Lapton said they could not disguise the fact that the Act would bring great help to the poorer classes, in respect of domiciliary treatment, but at the same time there was no doubt that the effect of the Act had been to put them into a position of great difficulty. Although there had been decreases in other departments, the in-patients continued to increase, and the problem which faced them was—how to get £50,000 or £60,000 a year to run the new buildings they would have to erect. He thought if they made a combined demand they would get the money. Dealing with the question of a possible reduction in subscriptions if State aid was given, the speaker said he thought it would be better if, instead of taking large sums in general aid of hospitals, they should say to the Insurance Commissioners, ''We shall be

glad to take your insured patients so long as you pay for the cost of the treatment in our wards." (Applause.)

Mr. Carnt said he did not think they were likely to get at the present moment pro rata payment for insured persons from the Government, and it seemed to him if they took advantage of the clauses which were already in the Act, so far as they went, and if they endeavored to get those clauses amended, hospitals would benefit to some considerable extent, and they might recover from the State the money they were likely to lose in annual subscriptions in consequence of the initiation of the Act. He thought the clause in the Act which said "Societies may enter into agreements with hospitals" should be altered to "shall enter, etc.," and if that were done he thought they would get a considerable sum of money among the voluntary hospitals. He suggested that the Conference should pass a resolution to that effect.

Dr. Mackintosh quoted the following words from the Act, bearing on this point: "In many cases the society may think it desirable to use the money to help the member over the difficulties incidental to his illness—for example, by paying his rent or providing him with necessaries."

Mr. J. H. Cooke (Winsford) thought they need not trouble about State intervention, because State authorities were more bankrupt than hospitals, but he hoped it would never come to a case of State intervention. He pointed out that under the Public Health Act every local authority had a power to contribute towards the maintenance and the sick of their district.

Mr. H. W. Deacon said the Act had not done them much harm at Liverpool, and they were not losing their subscribers.

Mr. J. P. Somers thought the public did not appreciate that cottage hospitals obtained about two-thirds of their income from subscriptions and one-third from patients' payments. If they could get 10s. or 7s. 6d., which the Act really gave, they would be able to go on, but if they did not, cottage hospitals would have to close for want of funds.

Mr. J. S. Neil said it was not a question of having more beds so much as the need of money to maintain them.

Mr. Macpherson said he understood an allowance would be made for hospital treatment as well as for sanatorium treatment, but it did not seem to have taken place so far. There must be

some arrangement made or else the voluntary hospitals would go down. The raison d'être of a hospital was that suffering should be given immediate relief, but they had to pay for the maintenance and support of the patient, and they could not do that unless they received something to enable them to do so.

Mr. Alvey said the problem before them was how to maintain the beds that already existed, and he was in entire agreement with Mr. Carnt as to the payment of sickness benefit. He did not think they must have entire State control. He believed the roots of the voluntary system were too deeply planted in the life of this community of ours for it to be so rapidly devitalized that it needed to be pulled up root and branch. Therefore, he was sure it was going to continue, although modified in many respects, to a very considerable extent. (Applause.)

Mr. Toulmin suggested that it would be a great help if they were to memorialize their different members of Parliament now that the Act was again before the House.

It was decided that no resolution should be passed, but that the matters raised should be referred to the Council.

AFTERNOON SESSION.

THE PROBLEM OF TUBERCULOSIS.

The afternoon session commenced with a paper by Sir Thomas Oliver (Professor of the Principles and Practice of Medicine, College of Medicine, Newcastle-on-Tyne) on "Tuberculosis and the General Hospital," and in the absence of Sir Thomas, the paper was read by the Rev. G. B. Cronshaw. We append the following extracts:

The discovery of the tubercle bacillus by Koch gave not only a fresh impetus to the study of preliminary and other forms of tuberculosis, but it united all the forms together and raised hopes that the malady would be brought within the sphere of prevention and cure. Since it is of all maladies the one disease which claims the greatest number of victims—50,000 annually in this country, or one-ninth of the total death-rate—the problem of tuberculosis remains for medical men one of the most fascinating of our time. In the wards of our general hospitals there are almost always cases of tuberculosis. With our increasing knowledge of the disease and of its infectious nature, we naturally ask

ourselves whether it is desirable that such a disease should be treated in general hospitals. It seems something of a contradiction that, while hygienists are teaching the necessity of segregating phthisical patients in their homes or of removing them to sanatoria, hospital physicians should be treating them in their wards. The experience of the Brompton Hospital is quoted to show that, given good conditions and plenty of ventilation, the infectiousness of tubercle is slight. Medical practitioners also tell us that only in a few instances, considering the opportunities for infection, is the disease directly conveyed from a sick husband to a healthy wife, and vice versa. Opposed to these there are instances on record of nearly whole families having been wiped out by the introduction into the home of an infected member. It is a question as to how far infection has played any notable part in spreading the disease in the wards of a large hospital. That flies are carriers of the disease, and therefore objectionable intermediaries, is now beyond all dispute. I must admit that in several experiments I expected more serious results to have followed inoculation of animals. With ordinary care as regards ventilation, cleanliness, removal and disinfection of the sputum, the risk of infection in the ward of an infirmary is not so great as to cause alarm; but the point rather is this: Is it wise to run any risk at all? What, too, is the best thing for the patient himself, and what is the best for others? There is also another side to the problem: Can the admission of tuberculous patients into a general hospital be altogether prevented; and, if so, is it desirable from a teaching point of view that they should be excluded? On the whole there is not the least doubt that the best results of the treatment of tuberculous patients are obtained by residence in sanatoria, and yet to sanatoria unqualified praise cannot be given, for results have not always come up to expectation. There is not the least doubt that those who adopt the open-air treatment of tuberculosis are proceeding on the most satisfactory and most hygienic lines. Compared with cattle which are housed during the winter months, and which thereby become susceptible to tubercle, the herds which live out-of-doors all the year round and roam about freely in the open do not suffer. An appeal is made to this fact in favor of the open-air life. But what of wood-pigeons sleeping on the tops of trees, breathing the purest

air, and yet dying from tuberculosis? Such a circumstance weakens our belief in the efficacy of pure air. Notwithstanding all this, the crowded ward of a general hospital is not the ideal place for the treatment of tuberculosis. There is not the quantity nor the purity of the air the patient requires. With this mixed experience before us, we return to the question: Ought tuberculous patients to be admitted into a general hospital? And to that I must return the answer "No" and "Yes." You cannot, in fact, keep them out. Tuberculosis is too subtle a malady, and its influences and ramifications are too widely spread to bring it under the unqualified ban of prohibited admission into a general infirmary. We come, therefore, to this, that there is a large number of cases of tuberculosis which cannot be kept out of an infirmary, owing to imperfect diagnosis; there are many cases of concealed tuberculosis which are treated therein satisfactorily; also that special hospitals, annexed to general hospitals, and sanatoria are places wherein the best results from treatment are obtained. The exclusion of cases of tuberculous disease from teaching hospitals would mean a serious loss to the education of the medical student. Unless we are prepared to allow all our voluntary hospitals to be taken over by the State, I view with a certain amount of apprehension the desire of local Insurance Committees to subscribe for, and therefore to have control of, a certain number of beds in a general hospital; for as the needs of the public become greater the demands of the Committee will also increase, and thereby alter the character of the institution and the original intentions of those who founded the voluntary hospital. As regards other places for the treatment of the tuberculous, there is not the least doubt that a special dispensary, such as recommended by Sir Robert Philip, is the place where patients should first be sent to, and there undergo a process of sifting. If the prevention of tuberculosis is to be the main thing aimed at, the treatment of affected patients in a general hospital is not the best way to accomplish it. Tuberculosis has become a national problem; it is no longer a question of the individual or his family. It calls for treatment in the mass, and not in detail alone. Special hospitals for the treatment of tuberculosis must therefore be established, provision being made for the hopeless cases as against those likely to benefit by treatment, and these hospitals will have

to be maintained by the municipality or by the State. As the years roll on the State is becoming more and more the guardian of the health of the public. One means by which she can do good in this direction is by not neglecting infected children, many cases of tuberculosis in the adult being the result of neglected infection dating back to childhood. (Applause.)

HOSPITAL TREATMENT ADVOCATED.

Dr. Duncan, in opening the discussion, said as it was utterly impossible for them to keep their hospitals free even from cases of tuberculosis in the advanced stage, he strongly advocated that every hospital should have separate special accommodation for such cases. He had come to the conclusion that tuberculosis was in some respects like typhus fever. If they had an infectious case treated in an insanitary and crowded atmosphere, where the air was not sufficiently renewed, tuberculosis was an infectious disease and spread with considerable rapidity, but if they had cases treated in a place where ventilation was thoroughly attended to, and the air changed, and the patients not too near one another, he did not think tuberculosis would spread in a ward. He thought they must continue to treat the disease in hospitals. They had a right to claim from Insurance Committees payment for the treatment of these cases. The wording of the Act did not confine the disease to the disease of the lungs, but any case of tuberculosis might be claimed for. (Applause.)

AN OXFORD SCHEME.

Dr. Brooks said he thought they could run the infectiousness of tuberculosis to the death, and if they took too strong a line as to this being an infectious disease, they would prevent a great deal of good work being done economically. He believed that the best treatment the tuberculous patient could get was the hospital treatment, and they would cripple their hospital doctors in their work amongst classes other than the hospital classes if they took a large number out of their hands. They had brought out a scheme in Oxford which he thought was not a bad one, to link up the Radcliffe Infirmary with the Insurance Act so far as tuberculosis was concerned. One had to remember that a hospital existed for the poor. This invasion of the State was one which was going to affect the poor, and, if hospitals turned their backs on the Insurance Act generally, or the tuberculosis side of the

Insurance Act particularly, they were going to wipe away from the usefulness of the general hospital an enormous amount of their clientele. Time had been too short for a thoroughly adjusted scheme to be brought out. They, in the voluntary hospitals, were naturally proud of being on the staffs as voluntary doctors, but he thought they would have to face the fact that the Government was putting in another series of practitioners, whom they must either connect with the hospital or leave alone, and let them form hospitals of their own. Their present scheme, which had been accepted by the medical men in Oxford, was really to give facilities at the hospital for the Insurance Act patients, so far as tuberculosis was concerned. He believed that on the whole this was about the best plan they could have evolved. After they had had a year or two's experience no doubt closer relationship would be formed between the new department they were opening and the hospital itself. At present they were in a muddle. The hospital people thought of it from their point of view, the local insurance people from theirs, and the County Council from theirs. They had the three different bodies to consider. They were not offering any very tight connection now, but they were not turning their backs on those great developments and saying that they would not have anything to do with it. He believed that in the end some scheme would be arranged, when time had shown the best direction and the first excitements of the working of the Act were over, which would connect this and other parts of the Insurance Act closer with the general hospitals.

RADCLIFFE INFIRMARY AND THE CITY COUNCIL.

The Rev. G. B. Cronshaw (treasurer of the Radcliffe Infirmary) said the main basis on which they were doing this work in Oxford was the prevention of tuberculosis, and clearing it out of the area in which they worked at the Radcliffe Infirmary. They took a whole survey of the disease. They followed it into the schools, with a thorough inspection of school children by different agencies, and through the new department. Where did the hospital come in? The Radcliffe Infirmary was trying to come in in two ways—by allowing that department for the City to use their out-patient department, to let cases come in any time they wished, to allow their tuberculosis officer to make that his centre, to keep all his case notes there, to see all his patients, and to use the facilities of the hospital in all its special departments.

He felt absolutely certain if they did not help in this work, if as hospitals they were going to stand aloof, and say "No," they were betraying the sacred trust reposed in them. If they stood aloof it meant the duplication of every department they had somewhere else in the town. They had had one experience in Oxford of that, and they did not want another. They had tried as hard as they could to come into contact with the City, and after a great deal of pushing from Sir William Osler and some of them they had now definitely taken up this work, with the view to treating it from the preventive point of view. They had tried to come to some agreement, and, so far, they had succeeded. As to institutional treatment, the city, subject to the Local Government Board's sanction, were about to agree to take six of their beds from year to year, but one year only at a time. When these beds were filled they would be treated by the hospital medical staff, and the beds would be under the complete control of the hospital. The City Council were prepared to take these six beds at 30s. per week, a pro rata payment, and they were going to give them a sum, which might be £150, in addition, as a donation to the general funds of the hospital. This might mean a subscription from the City Council of nearly £550 a year. He was prepared to accept that, because £550 would keep his six beds going. They could not erect another ward with the upkeep always baulking one, but if the County would come in and take another ten or twelve beds they would have the upkeep for another ward provided for. (Applause.)

Mr. E. L. Blake (Oldham), Mr. E. S. Kemp (London), Mr. Cooke, Sir Henry Burdett and Mr. Fitzgerald (Chester), also took part in the discussion.

Sir William Osler, in bringing the session to a close, said practically from the standpoint of the wards all forms of tuberculosis might be admitted safely, except the advanced open cases. He claimed that the dispensary of a general hospital for the treatment of tuberculosis might be made ideal. The work done in connection with social service at St. Thomas' Hospital indicated that they would never get on with this work until the housing conditions under which the patients lived were improved. (Applause.)

The visitors afterwards inspected the Radcliffe Infirmary and the new buildings, and were entertained to tea.

MORNING SESSION, JUNE 28TH.

The Conference was resumed on Friday morning at 10 a.m. Mr. Keith Young, F.R.I.B.A., read a paper on "The Upkeep of Hospitals." He said perhaps the most important point in regard to planning was the arrangement of corridors and intercommunication generally. Two vital points to be observed in laying out the lines of communication in a hospital were: (1) That the length of corridors should be reduced to an absolute minimum; and (2) that the routes to all departments to which patients have to be directed should be as simple and obvious as possible. In these days the work of sterilizing had grown to so great an extent that a steam boiler had become a necessity in all but the smallest class of hospital. And when steam was to be installed there could be little doubt that every possible use should be made of it. The whole of the water, both for warming and for supplies to baths, sinks, and lavatories, should be heated by steam; live steam would, of course, be used for cooking, for sterilizing, for disinfecting, and for heating steam kettles and plate-warmers in ward kitchens. As to the last two points, Mr. Carnt, the general superintendent of the Manchester Royal Infirmary, told him that by substituting steam for these purposes he had effected a saving of £350 per annum in gas without increasing the coal bill. Without going into the rather difficult question of whether a hospital ought to have a works department or not, and, if so, to what extent it should be carried, he thought that in all except the smallest class of hospital some arrangements should be made for carrying out repairs to electric light work, plumbing and engineering, and, to a limited extent, painting. The annual cleaning of wards or extensive works of painting could not, he thought, be undertaken economically by the employment of direct labor. Work of this kind, to be thoroughly well done, involved the employment of a skilled staff, and could not be well or economically carried out by the aid of a scratch team of men got together for the purpose. (Applause.)

The business meeting followed, at which the Council and honorary officers for the year were elected.

Friday afternoon and Saturday were devoted to visits to colleges, and to excursions to various places in Oxford and the neighborhood.

THE HOSPITAL CONFERENCE AT OXFORD

THE visit to Oxford of the British Hospitals Association falls at a critical time in the history of our own Radcliffe Infirmary and is that of voluntary hospitals generally, both in London and in the provinces. Fortunately for Oxford and the county a very timely legacy of a very considerable amount has put our own Infirmary in a fairly strong position just at the time when fresh calls are being made for a very considerable development of hospital work. It is not possible at present to forecast the full effect of the National Insurance Act upon hospitals, but this much is certain—that while trivial out-patient cases have diminished, the more serious cases demanding in-patient treatment tend to increase. On the one hand the hospital will not do the work of the medical practitioner in looking after his insured patients in illness that is not serious; but on the other hand the medical practitioner will naturally wish to pass to the hospital wards all cases of serious illness among his insured patients, for thus he benefits both himself and his patients. The doctor being paid not by attendances but by the number on his list, he will naturally make as much use as he can of the hospital, and from the point of view of public health this will be all to the good, but it will put a severe strain upon hospital funds. There is another direction in which the Insurance Act will tax hospitals. Throughout the country they are taking a prominent part in making provision both in dispensaries and in special wards for tuberculosis patients. It remains to be seen whether the voluntary system will bear the strain. It must not be forgotten that the Insurance Act in another way directly taxes hospitals. The staff must be insured, even though in the event of illness these persons, as is always the case, are treated without charge in the hospital and continue to receive their salaries. The Insurance Act lays a very heavy tax upon employers and employed. In some parts of the country it is the great employer of labor to whom the local hospital looks for support; the rich men are its mainstay. But in other places, especially in the manufacturing centres, the working classes provide as much as half of the hospital income. Between them, employers and employed have to find seven-ninths of the contributions under the Insurance Act—the other two-

ninths fall upon the whole community in general taxation. What difference will this make in the volume of subscriptions and donations to hospitals? The demands for hospital expenditure are increasing, the income may be diminishing. There is one way in which, without making any contribution which would bring with it state control, the hospitals could be assisted, and ought to be assisted, by the state. On all bequests to hospitals there is a legacy duty of ten per cent. This should be remitted, and this would make to hospitals a much greater difference than the mere addition of one pound to every ten bequeathed. Many more legacies would probably be given. Many are probably withheld through a dislike to pay this heavy tribute to the Chancellor of the Exchequer.

In a few years we shall be celebrating the bicentenary of the Voluntary Hospital. The first to be founded by voluntary subscriptions was in the year 1716. It is not probable that by 1916 the voluntary hospital will have followed the voluntary school and been absorbed by the state, but it is most unlikely that the voluntary system will last for any very long time. This is not because the work is negligently done; there never was a time when so much money and so much care were given to the work of providing for the sick. The hospital must have the best of everything, the best in medical treatment, in nursing, in equipment, in food. The standard is higher than it has ever been before. The natural result is that the demand for hospital accommodation increases. Operations are now performed with success that were considered impossible even a short time ago, but in appliances, equipment and nursing the outlay is much heavier. As the conception of what can be done and ought to be done is enlarged, so it must follow that the task of making adequate provision for the wider field becomes much harder when thrown upon the comparatively few voluntary subscribers. Hence, the standard of hospital provision differs very much in different parts of the country. In some places the sick poor can get the very highest skill and knowledge and the latest resources of science placed at their disposal; but in other places the accommodation is old-fashioned and inadequate, and the chances of recovery very much less than in more favored localities. People often talk as if all the hospitals in the country were

financed by voluntary subscriptions. That was true in the 18th century, and through the first half of the 19th, but the state today provides out of public funds for more than half of the hospital patients in the country. The Act of 1867 for the first time enabled the guardians of the poor to classify and treat the sick in infirmaries "kept distinct from the rest of the workhouse." Since then an immense improvement has been made in the condition of the infirmary wards of the workhouses. The modern Poor Law hospital can, in the best-managed institutions, compare favorably with the voluntary hospital, but while the voluntary hospital is for those who are curables, the infirmary wards are more in the nature of a hospital for incurables. Most of the inmates are old and infirm, and find a shelter there for their closing years of life. There is another class of hospitals under the control of local authorities, namely, hospitals for infectious diseases. Originally, the few existing were, like the general hospitals, under voluntary management, but frequent epidemics convinced the ratepayers in the large towns that fever, smallpox and diphtheria hospitals must be provided wherever needed, for zymotic diseases are dangerous and costly to the whole community. Originally they were built for paupers only, but after the report of the Fever and Smallpox Hospitals Commission in 1882, the pauper character of these isolation hospitals was removed, and the number of these institutions has enormously increased. The voluntary hospital, therefore, by no means provides for all the sick poor in the country—it leaves to the state and the local authority the care of the pauper and of those suffering from infectious diseases. Its field, however, is still a very wide one; it alone makes provision for surgical cases, and even where paupers are concerned the general hospital is used, and patients are not sent to the workhouse infirmary if there is a hope of a cure within a reasonable time.

Noble efforts have been made within recent years to raise the great hospitals in London from the condition of penury into which they had fallen. The Hospital Sunday Fund in forty years has made grants to the London hospitals of two millions of money. Then there is the Saturday Fund and the King Edward Fund. But it is necessary not only to maintain existing hospitals at the higher standard demanded by instructed public opinion,

but also to build new hospitals to keep pace with the growth of the population. We believe that this has been done in the great industrial centres, but not in London; but neither in London nor in the country generally is there such a ratio of beds to population as there is in Germany, where hospitals are public institutions. It is inevitable under a voluntary system that hospitals should be ill-distributed; the population tends to migrate in London from the centre to the suburbs. The old hospitals remain where they were first planted, and there are large and populous areas with no supply. In provincial towns the raising of adequate funds is a growing difficulty. Much depends upon the influence and energy of the local committee and its chairman, much upon the chances of legacies, much upon the perseverance shown in canvassing for new subscribers. A convalescent home should be regarded as a necessary part of a hospital, but comparatively few hospitals have convalescent homes attached to them, and in any case their finances are generally separate, and the convalescent home finds it still harder than the hospital to obtain adequate support. Few patients are fit to go straight from hospital back to the working-class home. The voluntary system has certainly produced great results. If it fails to cope effectively with the increasing amount of work thrown upon it, it will be because under it the standard has been continually raised. Compare the present wards, the operating theatres, the nursing, the food, with what was considered adequate thirty years ago. There is more work to be done of a more expensive kind than formerly, there is also more competition for funds. Here in Oxford, for instance, we have an Eye Hospital and a Nursing Home. Should the change from private to public control ever come, there is no reason to fear that those who have given their best work to hospital management would not have the fullest opportunity to continue to serve either as representative members or as co-opted volunteers; but we have no wish to anticipate the day when the voluntary hospital shall pass under the control of the State and local authority.—*Exchange.*

WHY WARM AIR SHOULD BE HUMIDIFIED

THE subject of humidifying the atmosphere of a hospital is all too frequently neglected, and the following opinions from various health authorities are interesting:

Dr. Henry Mitchell Smith, Brooklyn, N.Y.: "The relative humidity of any locality is of the greatest importance, but in regulating the 'climate' of our homes in winter this factor is entirely overlooked."

Chicago Health Department Bulletin: "Dry indoor air is the greatest cause of discomfort, the source of much ill-health, catarrh, colds and other diseases of the mucous membranes."

Dr. William F. Colbert, Philadelphia: "From a physician's standpoint, the relative humidity in the house during the winter months should be maintained between 60 and 70 per cent., as it would produce a distinct decrease in the number of catarrhal conditions of the mucous membrane of the respiratory tract."

Dr. W. A. Evans, Health Commissioner of Chicago: "Of course, the first thing that one criticizes is the fact: they have no provision for humidifying the air."

Dr. A. P. Reid, Chief Health Officer, Department of Public Health, Nova Scotia: "Since normal moisture is more necessary than heat, the more I think of these conditions the more my wonder is, not that we suffer under disease, but that we get off as well as we do."

Dr. Howard T. Barnes, McGill University: "The importance of the influence of a dry atmosphere on the human organism has been in a great measure overlooked."

Dr. Leonard Hill, London, England: "When such air is heated, it holds such a low percentage of moisture that its capacity for evaporation is great enough to considerably chill anyone with whom it comes in contact, and the higher temperature of their dwellings is in consequence a necessity."

Hospital Intelligence

A Wing

Berlin and Waterloo Hospital (Ontario) is making a needed addition under the supervision of Mrs. Bowman, the superintendent.

More Money Wanted

Vancouver General Hospital is asking for $10,000 from the city to meet last year's deficit, and also asking for a per capita grant of 60 cents per day instead of 45 cents.

New Vancouver Hospital

St. Paul's new hospital on Burrard Street, Vancouver, is being rushed to completion. The cost is estimated at $450,000. It is five storeys high and 200 feet long.

New Hamilton Hospital

Hamilton, Ontario, is planning a large and modern hospital to be erected on the Mountain. The present idea is that the new institution should be built on the unit system, the various sections being erected as needed. Of course, to start with, there would be an administration building. The cost has not been figured out yet, as it may be ten years or more before the final touches are put to the proposed institution. The work will be started at once, as the present hospital is seriously overcrowded.

Hospital Matters in Sydney

Sydney has not yet found an answer to the hospital question. Twelve years ago an emergency hospital of thirty beds was established by the Dominion Iron and Steel Company; and it has been maintained by them, with the assistance of the usual provincial grant, until the present time. This hospital—the Brooklands

Hospital—has been used to the limit of its capacity by the general public as well as by the employees of the Steel Company, and, at first, the need for a more adequate hospital was not greatly felt. As the city became larger and the population increased, however, it became evident that a larger institution was needed, and that the accommodation provided by the Brooklands Hospital was only sufficient for the employees of the company to whom the hospital belonged. Accordingly, last September, the president of the company intimated that patients, other than the steelworkers, could not be admitted to the hospital after a certain date; he offered at the same time to give the Brooklands property, with its building and equipment, to a properly organized board of trustees, on the condition that reasonable terms be arranged for the treatment of the employees of the Company and an assurance given that the work of the hospital be efficiently carried on. The proposal did not meet with the full approval of the civic authorities, who rather favored the establishment of a separate municipal hospital, and, with this in view, voted the sum of seventy-two thousand dollars. The opinion obtains among many of the medical men of Sydney that the action of the City Council in this matter is open to criticism. The position occupied by the Brooklands Hospital is an ideal one, and the best available, and it is understood that, had the offer been accepted, the Dominion Iron and Steel Company would have given very material assistance to the new hospital. If the municipal hospital is established, the Steel Company will maintain its separate hospital, and the municipal institution will lose the revenue that otherwise would come to it in return for the treatment of employees of the company. The matter is not yet settled, and perhaps some happy compromise may still be effected.

Hospital Advance in Canada

Strathroy, Ontario, contemplates additions and alterations to its hospital at a cost of $6,000.

The Board of Directors of Victoria Hospital, Prince Albert, Sask., have approved plans for a new isolation hospital costing $7,000.

The Northwestern Hospital Company, of Edmonton, Alberta, incorporated in March of the present year, are purchasing a site

in that city on which to erect a four-storey hospital to cost $100,000.

A number of ladies of St. Mary's, Ontario, have started a movement for the establishment of a public hospital in that town.

The citizens of Saskatoon, Sask., are discussing the question of the best available site for the new City Hospital.

The new Bowmanville, Ontario, hospital was recently opened by Lieutenant-Governor Gibson in the presence of a large number of citizens. Miss Mabel Bruce is superintendent.

Dr. Hall, of New Westminster, B.C., has donated two acres at Port Coquitlam for a city hospital.

Quebec is looking for the best site for the construction of a new civic hospital, for which the city has been authorized to borrow the sum of $75,000.

The Board of the Vancouver General Hospital recently made application to the City Council for an increased grant of $30,000 to cover a deficit, making the total grant requested $78,000.

The National Sanitarium Association

The annual report for 1911-12, being that for the fifteenth year of the National Sanitarium Association, and that for the eighth year of the Toronto Free Hospital for Consumptives, has been issued. These reports embrace the work of the Cottage Sanatorium and the Free Hospital at Muskoka, as well as the work from the two institutions at Weston, namely, The Toronto Free Hospital and The King Edward Sanatorium.

A summary shows that 6,778 patients have been cared for at a cost of $127,331.06. Of the 6,778 patients, 2,809 were maintained without expense to themselves. The directors of these institutions prosecute a vigorous publicity campaign and collect goodly sums of money from their sales of Christmas stamps and from contribution boxes. They have a field secretary, who does valuable work, and also a purchasing agent for all the institutions.

Proposed

A new hospital is talked of for Newport, Va. S. R. Buxton is on the promoting committee.

A Select Private Hospital

"Simcoe Hall," Barrie, Ontario, "A select private hospital for functional and organic nervous diseases, neurasthenic and digestive disorders," has now been running for one year. It has proved itself a strong factor to the people of Ontario, and Canada, at large, and has the confidence of the medical profession, as it is run on strict ethical lines, having nothing of the publicity of a hospital, having no wards, but only single rooms and suites which give to each patient that absolute privacy they so eagerly desire.

The applications for treatment are so numerous that the directors will soon find it necessary to erect additional buildings. The ornamental grounds have been greatly improved this summer, a beautiful Elm Avenue has been laid out, curving past the Trout Pond, and winding around to the foot of the terraces in front of the main entrance.

New tennis courts, bowling greens and summer houses, have been added, which aid in the outdoor treatment so beneficial to this type of case. The careful supervision and individual attention given to each patient are important factors in the success of the hall. No time is diverted to the training of nurses, and only graduates of well recognized training schools are employed. The hydriatic department is modern and up-to-date in every particular, containing continuous baths, electric baths, sprays, Scotch douches and electric cabinets, the Galvanic, Faradic and Sinusoidal current supplies ample treatment for the various types of nervous diseases.

Simcoe Hall offers a warm welcome to patients who are on the verge of nervous breakdown.

Hits Hospital Both Ways

A bill providing against the abuse of free treatment in hospitals and dispensaries has been introduced in the Senate by Mr. Gerberich, of Lebanon, Pa. It provides that any person obtaining medical or surgical treatment on false representations from any hospital or dispensary licensed under the bill shall be guilty of a misdemeanor, punishable by a fine of not less than $10

and not more than $250. The bill provides that the State Board of Charities shall issue licenses to hospitals and dispensaries only when it is shown that such institutions will be for the benefit of the public.

Money Asked For

The trustees of Pittson (Pa.) Hospital are asking the State for $18,000 to increase facilities.

Dover Hospital

The Legislature of Delaware have appropriated $25,000 for a hospital at Dover. It will be maintained from its private business and by money raised from the citizens.

New Hospital

The new Oneida (N.Y.) County Hospital is completed. It is now being furnished. Dr. S. Ginsberg applied for the superintendency.

Contagious Hospital

Glen Falls, N.Y., is to have an isolation hospital. Drs. Palmer and Hall of that town are active in forwarding the movement.

Hospital Promoted

The Lauderdale County Tuberculosis Association, under President McKay, of Meriden, Miss., are aiming to build a sanitarium.

Another New One

Columbus, Ga., is to have a city hospital, much needed. Two hundred and fifty prominent citizens have petitioned for it. It will cost $60,000.

Farms For Hospital Sites

Farms are being bought in the vicinity of Syracuse, N.Y., upon which to build a tuberculosis hospital. The whole State of New York is active in fighting the white plague.

St. Anthony's Campaign

By a whirlwind campaign of eight days effort was made to raise $150,000 for St. Anthony's Hospital for Incurables, Brooklyn. A similar effort was made to raise $100,000 for the Columbus Hospital, New York. These are both Catholic institutions.

Hospital Planned

Plans for a new hospital at Martin's Ferry, O., have been completed; work of construction is commencing.

Dr. Moe Busy

It is proposed by Dr. Moe, late of Heron Lake, Minn., with his wife and associates to erect a $150,000 hospital at Sioux City, Ia.

New Hospital for Joliet

A hospital is proposed for the town of Joliet, Ill.

Amateur Actors Assist

"The Players," of Rockaway Beach, L.I., are assisting the hospital by giving plays.

A Wise Precaution

No county tuberculosis hospitals in New York State may in the future be located on almshouse grounds, according to a bill which Governor Sulzer signed on April 30th.

Another Campaign

The Social Service Hospital of Los Angeles, Cal., held a whirlwind campaign in early May to raise a fund of $250,000.

A Sisters' Hospital

The Benedictine Order of Sisters are planning to build a new hospital in Poughkeepsie, N.Y. The building will be a two-storey structure and will cost $100,000.

A Deficit Met

Brockton Hospital, Brockton, Mass., has appealed to the citizens for $14,000 to meet current expenses for the year and to pay off a deficit of $5,000. Collections in the churches on the last Sunday in April and private subscriptions raised the amount.

Bequests and Donations

The following bequests and donations have recently been announced:

St. Vincent's Hospital, New York City, $10,000 by the will of Katherine I. D. Harned.

Mount Sinai, Beth Israel, Presbyterian and St. Vincent's Hospital and Montefiore Home, New York City, each $5,000 by the will of Moses Weinman.

House of Rest for Consumptives, New York City, $100,000, to be designated the Amelia Sturges Morgan Memorial Fund, and Dr. James W. Markoe, New York City, an annuity of $25,000, by the will of John Pierpont Morgan.

Presbyterian Hospital, New York City, $15,000, and St. Vincent's Hospital, on the death of the testator's husband, $30,000, by the will of Mrs. Cornelia Eaton.

Harrisburg, Pa., Hospital, $5,000 by the will of William H. Boyer, New York City.

Rockefeller Institute for Medical Research, $200,000, the income of which is to be used "to investigate into the causes and

nature of cancer, and methods of its prevention and treatment," by the will of Henry Rutherford, Grand Isle, Vt.

Rockford, Ill., Hospital, $60,000, for an addition to be known as Emerson Hall, donation by Mrs. Ralph Emerson.

Campaign for Lebanon Hospital

On June 4th began a campaign to increase the membership of the Lebanon Hospital Association (Jewish) from 2,000 to 3,000. The hospital has done good work since its inception in 1890. When the Slocum disaster occurred on June 15, 1904, the superintendent, physicians and nurses rushed to the scene. Through their heroic efforts many were rescued from the water and flames, and many of the injured received shelter and treatment. A certificate of honor was awarded by the United States Volunteer Life Saving Corps to the superintendent, William Daub, for his bravery, and credit and praise were given the entire hospital staff.

Henry Phipps Clinic

The Henry Phipps Psychiatric Clinic, in connection with Johns Hopkins Hospital, was opened on April 16th.

The building is five storeys and has accommodation for about 100 patients. On the first floor are two observation wards and clinical and chemical laboratories.

A library and lecture hall, wards for patients and the private rooms of the superintendent and other physicians of the clinic are on the second floor.

The psychological and histological laboratories and research rooms and two convalescent wards take up the third floor. On the fourth floor are the single rooms and suites of rooms for private patients, while on the fifth floor are the roof gardens, the gymnasium, recreation grounds, and assembly rooms. Upon each floor are balconies, porches and every convenience for open air treatment.

Changes in Hospitals

Work has begun on the new $200,000 six-floor surgical wing of the University Hospital.——A decision has been reached in the competition for the Jewish Maternity Hospital, to be built at Fourth and Spruce Streets, to cost $50,000.——The medical and surgical departments of the hospitals of the Woman's Medical College of Pennsylvania were established in 1904. All departments of medical and surgical service for men, women and children are here conducted by the college faculty. This is the main branch of the hospitals; it immediately adjoins the college building.

PERSONALS

We had the great pleasure on July 10th of receiving a call from our esteemed collaborator, Mr. Conrad W. Thies, Hon. Secretary of the British Hospitals Association. Mr. Thies passed through Toronto on his way to Winnipeg, where Mrs. Thies has been visiting for the past two months. We only regret that our distinguished friend and co-editor was able to remain so short a time, though we hope to see more of him on his way back from the west.

Book Reviews

The Operating Room and the Patient. By RUSSELL S. FOWLER, M.D., Chief Surgeon First Division, German Hospital, Brooklyn, New York. Third Edition, rewritten and enlarged. Octavo volume of 611 pages, with 212 illustrations. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, $3.50 net.

The author has endeavored to simplify technic. Simplification and standardization are the keynotes of the hour. He holds that the underlying principles of successful surgical treatment are: careful anesthesia, exact hemostasis, asepsis, rest of the injured part, use of the rest of the body, feeding advanced to normal as fast as the stomach can care for it, and observation of the general rules of hygiene.

Subjects treated are: the operating room; preparation of supplies and instruments; bandaging; anesthesia; pre-operative preparation and the primary dressing; after-treatment; care of the wound; hemorrhage; complications from antiseptics, pressure, and circulatory complications; operations on special tissues, the head, neck, thorax, abdomen, rectum and anus, kidneys and ureter (extraperitoneal), the bladder, male and female genitals, and the vertebrae. A list of instruments and dressings commonly employed is given in conclusion. The work is well illustrated and is a readable and instructive volume.

Manual of Medicine for Nurses and House Mothers. HOXIE and LAPTARD. 2nd edition. Philadelphia: W. B. Saunders Co.

The first edition of this work appeared under the title, "Practice of Medicine for Nurses." An alarming after-thought seems to have forced itself upon the authors, who express a fear that "Nurses may venture outside their proper niche, and begin giving doses." For this reason the name of the book has been changed.

The work will find a place in the library of a nurses' club, and may be profitably read by pupils in connection with regular studies. It can be recommended as especially suitable for the home and house mother. M. C.

Obstetric and Gynecologic Nursing. By EDWARD P. DAVIS, A.M., M.D., Professor of Obstetrics in the Jefferson Medical College, Philadelphia. 12mo volume of 480 pages, fully illustrated. Fourth edition, thoroughly revised. Philadelphia and London: W. B. Saunders Company. 1913. Buckram, $1.75 net. Sole Canadian Agents, The J. F. Hartz Co., Ltd., Toronto.

The author outlines the nursing of normal pregnancy, and also that of pregnancy with complications. Next comes the preparation of the lying-in room and the duties of the nurse during labor. Then follows the care of the mother during the lying-in period, the care of the baby, nursing of septic and maniacal cases, and the nurse's functions in obstetrical surgery.

Gynecologic nursing embraces a knowledge of the various postures, the use of pessaries, the methods of douching, and the general care of gynecologic patients.

Sterilization methods, preparation of the field of operation, the operation and the after-treatment are discussed. The handling of cancer patients and those with venereal diseases is discussed. An appendix describing proper dietaries, preparation of surgical supplies, completes the story.

A History of the Toronto General Hospital, Including an Account of the Medal of the Loyal and Patriotic Society of 1812. By CHARLES K. CLARKE, M.D., LL.D., Superintendent Toronto General Hospital. With twenty illustrations. Toronto: William Briggs.

Dr. Clarke has made a good contribution to hospital historical literature in this work. It will be read with very great interest by all who are, have been, or will be associated with the work of the Toronto General Hospital.

It appears the foundation of the hospital was made possible by the contribution of the Loyal and Patriotic Society of 1812 of certain medals prepared for, but for certain reasons never distributed to, the heroes of the war. These medals of gold and silver were worth some £750, were converted into bullion, and the proceeds applied to this charity. The various buildings built and used for hospital purposes by the successive Boards of

Management are described; sketches are given of the notable people who acted as trustees, superintendents and surgeons; and a history of the financial vicissitudes of the institution is given. Quaint quotations appear from the pens of early house surgeons, describing the crude methods of treatment adopted, even as late as 1870.

An account follows of negotiations which have led to the close affiiliation of the hospital with the medical department of the University and of the co-operation of the city of Toronto, the University, the Provincial authorities and the subscribers in establishing the greatest Canadian hospital, and one of the great hospitals of the world. May her scientific output correspond with her physical equipment.

Building and laboratories and equipment will not make this institution great. Men are required. The reading of this historical outline, it is hoped, may inspire some student to perform the work which will entitle the hospital to become famous in the scientific medical world.

A Reference Handbook for Nurses. AMANDA K. BECK. 3rd edition. Philadelphia: W. B. Saunders Co.

The first edition of this useful little book met with deserved popularity, its neatly bound, clearly printed pages furnishing an amount of information often needed by physician and nurse, and the matter contained varying from "Antidotes" to "Postal Regulations."

In the preface to the third edition, lately revised, the author declares her determination to keep the book "up to date." Some new methods, which recent experiments have proved valuable, are described; several new formulas for solutions, and preparation of food are given, and there is also a chapter on "Infantile Paralysis."

The book makes a very acceptable gift to a nurse, and is worth double the price. M. C.

The Modern Hospital; Its Inspiration; Its Architecture; Its Equipment; Its Operation. By JOHN A. HORNSBY, M.D., Secretary Hospital Section, American Medical Association; Member American Hospital Association, etc., and RICHARD E.

SCHMIDT, Architect, Fellow American Institute of Architects. Octavo volume of 644 pages, with 207 illustrations. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, $7.00 net; half morocco, $8.50 net. Sole Canadian Agents, The J. F. Hartz Co., Ltd., Toronto.

Within the next few years we shall see many additions made to hospital literature, in America especially. Following Grober's excellent book in German, by himself and colleagues, and Vandervelde and Le Page's new book in French, comes the above by Hornsby and Schmidt, of Chicago, from which city came a few years ago a large volume by Ochsner and Sturm.

"The Modern Hospital" is virile, outspoken and informing. It is naturally full of the Michel Reese Hospital, over which Dr. Hornsby has been superintendent during the past six years. The volume indicates that the author has been alive to the chief phases of hospital development which have taken place during his term in office.

A few points call for special reference:

The plans and description of the Sarah Morris—the babies' and children's department of Michel Reese—which appeared first in the *International Record* for March, 1912, are reproduced, and Mr. S. Schmidt is to be complimented on making so complete and satisfactory a building on so cramped a space. The wet nurses' living room should have been kept out of the basement, however. Wet nurses should be housed in a dry place.

Dr. Hornby's skill is shown in the pasteurizing plant depicted and described, and which is of his own invention. His child's bed also appears to be a marked improvement on the old styles.

The chapter devoted to nurses is spirited and controversial in character. The author condemns the unprofessional character of the graduate nurses, who, he avers, are standing for a sort of trades unionism.

The rules governing the various departments of the Michel Reese Hospital are reproduced. Those respecting surgical operating rooms are very good. The accounting system described is also well worthy of being followed.

The chapter on dish-washing is full of good points. The author recommends the variety of machine that he considers

best. This practice is followed all through the book in regard to equipment of various sorts. The plan is a good one. The kitchens are discussed, the author putting up a strong plea for keeping them near the ground, rather than usurping good space on the top storey. The laundry question is considered fairly fully and is informative.

Dr. Hornsby takes up the work of medical organization and discusses the relation of the various offices, one to another, but in these chapters he strikes no new note.

All through the work the scientific side of the hospital work is given deserved prominence.

The authors disarm criticism by their foreword. Possibly the book would gain in value by deleting the redundancies and retaining its many excellencies. Such compression would serve to make it a more sizable and convenient volume.

But, as it stands, the work is one of value to the profession and one worthy of a place in the hospital library.

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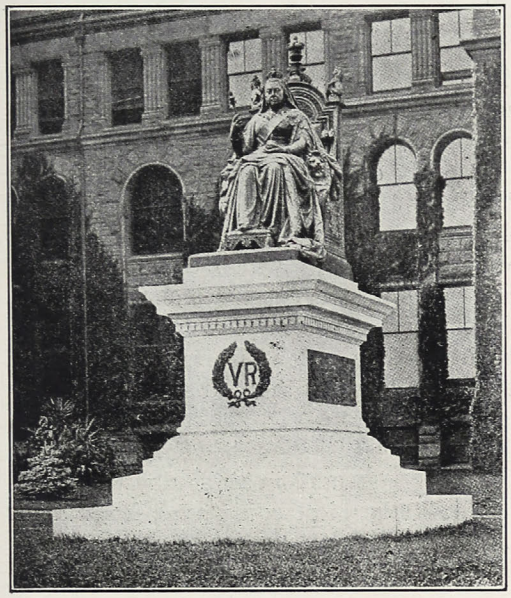
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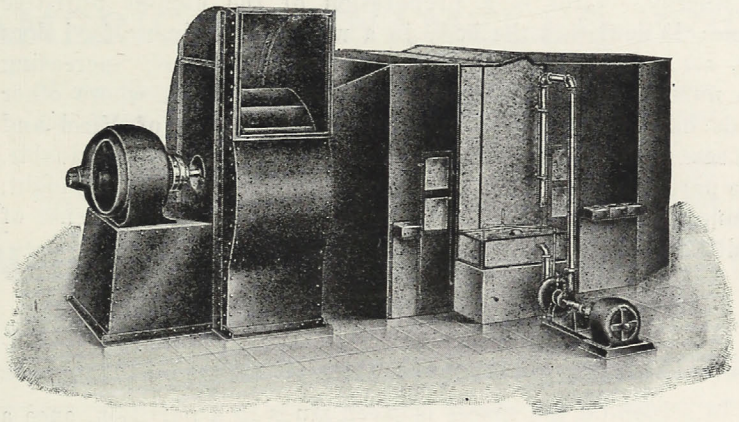
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Mr. Clarence W. Noble, 117 Home Life Bldg., Toronto, is General Sales Agent for Herringbone Metal Lath and Perfection Studs.

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A Preparation Particularly Suitable for Invalids

The attention of the readers of THE HOSPITAL WORLD is called to page iv of this issue, where they will see the announcement of Messrs. F. Edwards & Co., 18 Front St. West, Toronto. This firm are Canadian agents for Beck's German Lager, a preparation that is ideal for use in the private wards of hospitals and sanatoria. This lager is made from pure malt and hops, and is bottled only in Germany. Messrs. Beck & Co. are one of the largest exporters of lager in the world. They have branches in all of the British possessions and have built up their reputation upon the purity of their product. Beck's Lager has been introduced in past years into hundreds of hospitals, and the manufacturers would be pleased to have hospital superintendents try it in the different institutions throughout the Dominion. This preparation is obtainable from all wine merchants or direct from the Canadian agents.

An Ounce of Prevention

The Dustbane Mfg. Co., Ltd., Ottawa, Ont., placed a sanitary sweeping compound on the market five years ago, and to-day their product is known from the Atlantic to the Pacific Coast. Thousands of housekeepers are using the preparation with absolute satisfaction. It is in general use in Stores, Offices, Schools, and Colleges. A large number of Hospitals have also adopted this method of allaying the dust while sweeping.

Dustbane contains a disinfectant which, as it is being swept over the floor, purifies the air in the room.

No one should fail to give this preparation a trial, as the manufacturers plan for the distribution of Dustbane very liberally. They ship the goods, freight prepaid, to all parts of Canada, with the privilege of returning the unused portion if the goods fail to do all that is claimed. They go still further by offering to send free samples.

This preparation has been used in the office of THE HOSPITAL WORLD, which is a guarantee of quality.

The Good Old Summer Time

The coming summer season will no doubt produce its usual crop of cases for physicians, peculiar to the season.

Insect Bites, Bee Stings, Sunburn and its frequently following Dermatitis, Strains and Small Joint Injuries from baseball and other sports, Sprained Angles, Ecchymosed Eyes, Infected Wounds, etc., will demand the first attention of the physician and a second thought will be a suitable remedy.

All inflammatory conditions, whether from infective or traumatic cases, rapidly subside when dressed with Antiphlogistine. Its convenience of application with the assurance of satisfactory therapeutic results, makes it almost indispensable in emergency work.

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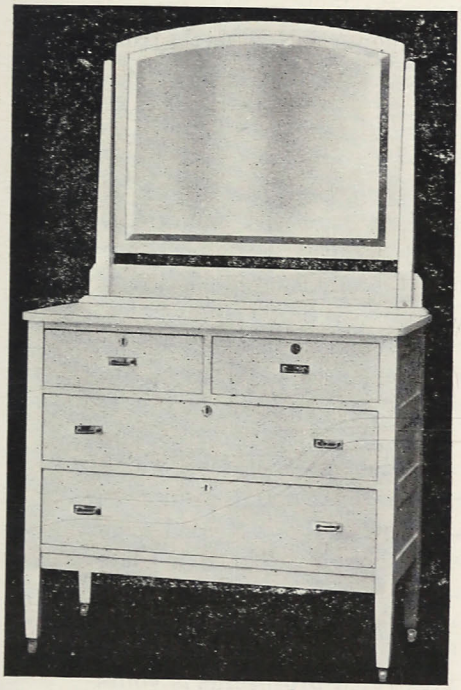
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A Liberal Offer by Toronto Electric Light Co., Ltd.

The Toronto Electric Light Company has purchased a pulmotor, which is an approved device for resuscitating persons apparently drowned, or asphyxiated by gas, or who have received a severe electric shock.

The pulmotor will be available on demand, free, for any necessary service which it is capable of performing. The Company's men at the Scott Street Station are being trained in its use, and one or more will be sent out with the pulmotor whenever a call is received for it. In emergency cases, the pulmotor may be obtained as quickly as an automobile can carry it by telephoning the Scott Street Station, Adelaide 404.

Another pulmotor has been purchased by the Toronto Power Company, and will be located at the Toronto Terminal Station, Dupont Street and Davenport Road; telephone Hillcrest 1830.

Many lives of persons who were apparently dead have been saved by the pulmotor when all other means of restoration have failed. Its value as a life-saver, which has been repeatedly demonstrated in other cities, appealed to the managements of the Toronto Electric Light Company and the Toronto Power Company so strongly that they have installed these two for the free use of the public.

Ambulance surgeons, physicians, policemen, firemen and others, who may realize the necessity for the pulmotor in cases of drowning, asphyxiation or electric shock, have only to use the nearest telephone, and a prompt response will be made from one of the stations mentioned.

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The best results can only be secured when the nurse or attendant is most thoroughly equipped to cope with conditions.

Massage is no longer a luxury for the wealthy, but a necessity for all classes, and the nurse who is thoroughly versed in the Swedish System of Massage, Medical and Corrective Gymnastics, Electro- and Hydro-Therapy, as taught by the Penna. Orthopedic Institute and School of Mechano-Therapy, Inc., 1711 Green St., Philadelphia, need have no fear of idle moments, in fact it is impossible for us to fill open positions. Daily, we are receiving telegrams and letters of inquiry for competent operators, which we cannot fill. The supply is not equal to the demand. Our next class opening, July 9th, is the last prior to the increased time and rate—is it not worth your earnest thought. The Fall Class opening, Sept. 23rd, means four months, and increased tuition fee. Why not be ready for an operator's as well as instructor's position by entering the Summer Class? The institute is always open for inspection, and our fully illustrated prospectus is yours upon request. It is pleasant reading and profitable, if embraced. Address, Max J. Walter, M.D., Supt., 1711 Green Street, Philadelphia.

The Hospital World

BUFFALO, U.S.A. TORONTO, CANADA LONDON, ENG.

An International Journal published in the interests of Hospitals, Sanatoria, Asylums, and Public Charitable Institutions throughout America, Great Britain and her Colonies.

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Editorials

THE HOSPITAL AND THE PRESS

It is universally agreed that the press can be of very great aid to any hospital, and it behooves every hospital superintendent to treat the press fairly, in the matter of giving news items for publication.

What these shall consist of must be left to the superintendent's good judgment, remembering always that there is no class of men possessing keener discernment and broader view than that of the press.

It is not only good manners but good business for the hospital to treat the newspaper man with courtesy, be he editor-in-chief or the much-belittled "cub reporter." Indeed the latter, out of his inexperience or disregard of newspaper ethics, is often to be more feared than his all powerful chief.

Following the usual office order, one man on the paper is allotted the hospitals. He "covers" one or more of them as part of his daily assignment. It is his duty to gather, day by day, any information or happenings concerning the institution that will be of interest to the general public. He has no personal interest in the matter. His inquisitiveness is not that of the private individual. He simply represents his paper, and in its name seeks news concerning a public institution which the public who support it would like to know—and have a right to know.

His desire to get something beyond routine news, some incident or happening such as every hospital experiences at intervals, a "story," in press parlance, is only evidence that he is animated by the same spirit that pulsates in every promising interne—the ambition to make a record and to stand well with his chief.

It is best, of course, that all news should be given out from the superintendent's office, by that officer himself, if possible, otherwise by his deputy. This should be clearly understood, both by the staff and the reporter. Routine items might be dictated by the proper authority and stenographed each morning, ready to be handed out to the press representative, who is often grateful to be spared the trouble and

time of preparing it himself. But the personal greeting and few words of the superintendent, whenever possible, do much to maintain pleasant relations between the hospital and the press, the thought of which gives the former much comfort when an alcoholic jumps from a second story window, or a careless nurse administers a lotion as a potion.

It would be well to stenograph a list of the legitimate items that may be given as routine news. This list could be added to as topics suggested themselves. It would be available for the acting superintendent, in the chief's absence, and of assistance to a newly assigned reporter.

Among the items might be: New buildings, addition of new departments, appointment of new members to the medical staff or new officers and assistants to the nursing staff, donations, public exercises such as anniversaries, annual meetings, etc. Reports of rare operations, new methods of treatment, and of especially interesting cases may also be made public, provided good judgment and a proper reserve in detail is exercised. Anything of a humorous nature is always acceptable, for the world dearly loves a laugh. Where a hospital incident is concerned the laugh is usually very kindly, for the outside public like the relieving thought that the hospital is not all sadness.

Concerning matters or incidents undesirable, it is best, under the reporter's questioning, to suppress as little as possible. A a rule he keeps a confidence inviolate, even at the sacrifice of "a good story."

Regrettable incidents occur in every hospital at

times. Suppression of facts or curt refusal to give out the same to the inquiring press is not the best way to deal with these. Frank acknowledgment of the same is often better. Treated with courtesy and confidence, the editor or reporter may be trusted to put the matter before the public fairly, and both press and citizens are brought into closer touch with the institution.

Suppress as little as possible. Do not be too sensitive to criticism. The greater the publicity given to the hospital administration, the stronger the public interest and the larger its sympathy. And even when the tired superintendent is called to the 'phone at midnight to verify or explain some undesirable news item that has been picked up by the press, it is well to remember that the inquiry is a legitimate one, and made in the interest of the institution as well as of the public.

The superintendent had better meet the situation with good grace and full information. The chances are that the item will be "crowded out" at the last moment, anyway.

THE HOSPITAL LABORATORIES

The establishment of laboratories to assist in diagnosis is variously viewed by the older practitioners. Some of them minimize its importance, while others go to the opposite extreme.

The hospital laboratory has not yet made its definite place and connection in the hospital scheme, but is rapidly so doing. The work carried on in the

laboratory must be intimately connected with the work at the bedside. The test tube must work beside the stethoscope and the facts revealed by each co-ordinated and correlated by one who is in touch with both the clinical and laboratory ends of the investigation.

Although the chief of the surgical or medical services may not have the time to study the laboratory findings, one of his assistants should. If a growth is sent from the operating room to the pathologist for examination, all the information possible concerning it should be given the pathologist by the clinician, and the former should be shown from what part of the growth the surgeon wishes his sections to be made.

The routine laboratory examinations of urine, sputum, stomach contents, feces, exudates, transudates, and other specimens, wherever possible, should be performed by an assistant (under supervision of the pathologist chemist) who is in touch with all the clinical features of the case.

In certain hospitals it has, of late, become the practice for the physicians and surgeons to send specimens for examination to a laboratory man who has no acquaintance with the clinical history of the case, and to accept his opinion without having looked at the process through which the specimen has gone.

The work of the two departments must be unified. Clinicians must learn more about the pathological methods, and the pathologists acquaint themselves with as many of the clinical aspects of cases as possible.

BRAIN RUSTING AND DUSTING

WITHIN a few weeks of each other, and on both sides of the ocean, two prominent physicians have been publicly discussing the great importance of practising physicians being kept up-to-date, and suggesting methods of accomplishing this. By the term up-to-date they imply not only that a physician should not be allowed to become "rusty" in the knowledge he acquired as an undergraduate, but that he should keep abreast of medical science, and have skill to apply the same in his practice.

Dr. Henry E. Hale, of New York, Instructor in Applied Therapeutics in the College of Physicians and Surgeons, in a recent interview, makes some very frank and forcible statements concerning this matter. He asserts that it is absolutely necessary that some plan should be devised to protect the public; and instances personal knowledge of cases where lives have been sacrificed or gravely endangered by the incompetence of licensed practitioners, who, presumably, so far failed to keep their medical knowledge available that they were unable to recognize or properly treat marked cases of ordinary disease. He suggests the rather drastic method of requiring physicians to renew their qualifications at periodic intervals, say every five years.

"I feel more and more," he says, "the importance of some method of testing from time to time the qualifications of practising physicians. My idea is that in order that a doctor should retain his license he should be required to take a test every five years to prove that he has the knowledge he once had, that he

has kept abreast of the advance of science, and that he has the skill to apply his theory to practical conditions."

These examinations, Dr. Hale thinks, should be conducted by the State and not by any medical society. They should be practical as well as theoretical, and half of the tests, at least, should be in actual treatment of cases. Patients in the hospitals should be shown to the doctors, and the latter required then and there to diagnose their ailments and mark out a course of treatment for them.

Specialists, he thinks, might have advanced tests in their specialty, and due allowance be made in such cases for a measure of weakness in general subjects.

"Moreover," said Dr. Hale, "it would be a splendid thing for the public and the profession at large if there should be some supervision of the men who set themselves forward as specialists. There would be far fewer instances of men of mighty poor qualifications going over to Germany for a few months and then sending around to their acquaintances, and sometimes to physicians who have never heard of them, cards announcing that they intended in the future to confine their practice to this or that specialty. The quantity of suffering that would be saved from a check on such practices none but a physician understands."

Regarding the hard-working general practitioner of the country place, Dr. Hale thinks that he should at least be expected to know the general outline of modern advance in medical knowledge. While it might not be fair to expect him to be expert in all the latest theories and methods of therapeutics he should at least know that they exist. He should be able to recognize when a case could be treated according to

new methods, if the patients could be brought into touch with them.

Professor Hale realizes that this proposed system of renewal of license would depend for its practicality entirely upon the manner in which it would be carried out.

Across the ocean, Dr. Osler in a recent address at Oxford refers to the same subject.

> "No body of men need more persistent brain dusting than do doctors. The profession of medicine is progressing at such a rate that in five or six years a man's knowledge is rusty, and it is a most important thing for the public that the average doctor should keep up to date."

Dr. Osler suggests not a test of fitness, but a method of keeping up that fitness. One way, he says, in which the doctor can keep himself thoroughly informed is by providing post-graduate courses in the county hospitals. He strongly urges the need of these educational centres. In place of country doctors or those practising in small communities going to great centres for knowledge he suggests that it be brought to them by a system of post-graduate instruction which he outlines.

It is questionable whether any such drastic method as a periodic examination for renewed licenses could be made compulsory. But it is evident that both of these physicians are impressed with the necessity of finding a method by which practising physicians may be kept up to that standard in medical knowledge which fits them to deal with human lives.

TRAINING IN FOOD VALUES

THE dietitian is not yet properly oriented in the hospital administration, and there is, consequently, apt to be trouble in connection with her department. A well-known Chicago hospital man recently asked the writer if he had ever met a dietitian who did not make more bother than her services were worth.

The hospital kitchen is one of the most important departments of the institution. One of the best-known hospitals in the country has placed a dietitian in charge of all food-preparation and dispensing in both main and diet kitchens.

In some hospitals a steward or stewardess is in charge of the main kitchen, while a dietitian, subject to the superintendent or to the principal of nurses, has charge of the teaching of dietetics to nurses. But there does not yet seem to be any uniformity in system upon this point.

The kitchen is as important a laboratory as is the bacteriological, the chemical or the pathological, and it will, in time, be presided over by one who is as much of an expert in food values and the physiology of digestion as is the official at the head of any of the other laboratories.

Our present method of feeding patients is crude in the extreme. A doctor untrained in dietetics prescribes, through the equally untrained interne and nurse, the diet the special patient shall have—this order being frequently expressed in the vague terms —full diet, light diet, or a liquid diet. The nurse so

requisitions the kitchen, and the cook sends up a quantity of food which expresses his own interpretation of the order, which may or may not be what the patient requires.

The food thus ordered is often also served in a manner, condition and quantity which makes it uninviting to the capricious invalid appetite. Much of it remains uneaten, and is consequently wasted.

This is a common condition in many hospitals, especially the larger ones, where it is a difficult matter to achieve delicacy of cooking and serving, and where consideration of individual tastes is almost impossible.

The remedy lies in training our doctors in dietetics as well as in therapeutics. The nurse should be as well up in the subject as she is in bacteriology. Each patient should have his prescription in proteids, carbohydrates, fats in proper proportion and according to caloric value, allowing as far as possible for the personal equation; and these should be combined to form attractive varieties of food, cooked and served in a manner that appeals to the invalid palate and suited to the individual needs.

Original Contributions

REPORT OF SPECIAL COMMITTEE ON GRADING AND CLASSIFICATION OF NURSES*

To the American Hospital Association:

At the fourteenth annual conference of the American Hospital Association, held in Detroit, the following resolution was adopted:

Resolved, That Charlotte A. Aikens, Ida M. Barrett, Emma A. Anderson, Dr. R. Bruce Smith and Dr. P. E. Truesdale be and are hereby appointed a committee to consider the grading and classification of nurses, with instructions to submit a plan of grading to this Association, for consideration at its next meeting.

Section 1. At the same meeting a communication was read from the General Secretary of the Thomas Thompson Trust of Boston, which has been working for several years to develop a practicable system of caring for the sick in the homes of persons of moderate means. This communication was referred to this committee for reply. It contained the following questions: 1. What is the proper curriculum for the training of "attendants" in small hospitals? 2. Can "experienced nurses" or "attendants" be properly trained outside of a hospital? If so, what is a proper curriculum for such training? As far as possible, the questions presented have been replied to, in the recommendations which follow.

The committee held its first meeting in Detroit, Dec. 12th and 13th, with every member present. At the request of the President of the Association, the Secretary, Dr. J. N. E. Brown, attended the three sessions of the committee held at that time. Inasmuch as a considerable amount of preliminary work had been done by the different members of the committee, and as a large amount of information gathered by previous committees was at its disposal, the committee decided to arrange for no other meeting before the issuance of the tentative report for the consideration of the members of the Association, but to meet in Boston one or two days in advance of the fifteenth annual

* Read at the Meeting of the American Hospital Association, Boston, Mass., August, 1913.

convention, for the final revision or ratification of the report, before its formal presentation before the Association.

As will be seen by the preface to the report, the committee availed itself of the labors of the two former committees appointed to deal with the training of nurses, and nursing problems in middle-class homes, and endeavored to build on the foundations made in previous recommendations, as far as possible, rather than to make recommendations which might raise again at this time questions which the Association had previously discussed, and, for the present, decided.

Miss Barrett reported regarding her inquiries into methods of classifying nurses in directories conducted by organizations of graduate nurses in various cities. It was learned that in many cities an attempt to classify nurses had been made. The distinctive terms which seemed to be most generally used were graduate or registered nurses, undergraduates, and experienced, tendants'' are registered, but the term is not commonly used by the public, as are the other terms mentioned, neither does or so-called practical nurses. In a few registries, so-called ''at- it seem to be popular.

Dr. Bruce Smith presented a report on nursing conditions in Ontario, and various parts of Canada, especially in relation to tuberculosis hospitals. Reports were presented from various other places, as to how the problem of tuberculosis nursing was being managed in the hospitals and sanitaria of the two countries.

Dr. Truesdale had made quite an extensive investigation into the various methods now carried on of training nurses outside of hospitals. A mass of information along this line has been collected, and is available to any who desire it. It can be had by applying to the Secretary of the Association.

GENERAL CONSIDERATIONS.

Section 2. The committee approached its task of making recommendations with the realization that it was dealing with an important sociological problem, which affects hospitals, nurses, physicians, and a large proportion of the people who are doing much of the world's best work, and living on moderate incomes. In framing the recommendations which follow, the members of the committee kept before them the following con-

siderations, which they respectfully urge shall be kept in the foreground in the study and discussion of the report:

(1) That the territory covered by the American Hospital Association extends over a vast area. It includes great stretches of country, in which hospitals are far apart, whole states and provinces, in which most of the hospitals are small, yet doing a work that is exceedingly valuable to the various communities. It also includes many important medical centres where hospitals and other philanthropies are numerous, and constantly on the increase.

(2) That in many communities in the west, southwest, and south, in which public spirit and philanthropic institutions are not as fully developed as in the eastern and central sections of America, privately owned hospitals have developed, and are now developing rapidly to meet the needs of the community, not met by municipal or philanthropic organizations.

(3) That the rapid increase in tuberculosis hospitals within recent years has created a problem in nursing which a decade ago did not exist, and that this problem is certain to increase as such hospitals multiply.

(4) That information gleaned from a great variety of sources goes to show what is undoubtedly true: that, numerous as are the admissions to hospitals, the sick thus admitted represent but a small fraction of the sick which have to be cared for. Apart from surgical patients, the vast majority of the sick, especially obstetrical and medical patients, and chronic invalids are cared for in the home. Statistics presented recently before the Academy of Medicine, New York, stated that 90 per cent. of those who are now doing nursing in America have had no hospital training.

(5) That the large number of newer openings for graduate nurses in social service, welfare work, public health work, and various other lines of philanthropy, combined with the increased demands for institutional nurses, have reduced considerably the number of nurses who would otherwise be available for nursing in homes.

(6) That there is a large part of the population in all states and provinces which is unable financially to meet the expense

of a graduate nurse at regular rates, even if sufficient graduate nurses were available to meet the demand.

(7) That the testimony of a large body of physicians, social workers, and interested workers for human betterment, goes to show that the needs in sickness in middle-class homes are not always best met by a highly skilled graduate nurse, but that a less expensive worker who can combine ordinary care of the sick with the care of the home, is often more desirable both from the standpoint of economy and efficiency.

(8) That there is a large gap in most communities not now filled by hospital service, visiting nursing or by private nursing as at present organized and conducted.

(9) That, owing to lack of organization, large numbers of patients, who are necessarily cared for at home, but who are acutely ill, and should have the most skilled care, are not able to secure it, because of the absence of any responsible, representative, organized body of people to study the needs of such patients and homes, and help to meet their problems. This condition leaves the field free to be exploited by all sorts and conditions of commercial organizations.

(10) That the promotion of economy and efficiency in the home care of the sick is inseparably bound up with the problem of the grading of nurses, their organization and supervision, and has a most important bearing on hospitals and hospital development.

A SURVEY OF THE FIELD.

Section 3. A general survey of the field shows the following groups or classes of nurses at work in the nursing field in the United States and Canada.

Regularly trained hospital graduates who have met the requirements or recommendations of the American Hospital Association for general training.

Graduates of hospitals for the insane.

Nurses trained in special hospitals, such as tuberculosis, maternity, infants, eye and ear, orthopedic hospitals, and homes for chronic and incurable patients, etc.

Partially trained nurses from general hospitals.

Nurses who have been in attendance at schools giving theo-

retical courses, with arrangement whereby experience is gained under supervision by nursing in private homes.

Nurses who have received their theoretical instruction by correspondence through commercial schools.

Nurses who have had class instruction under the auspices of a philanthropic organization, without provision for gaining experience under supervision.

Experienced or practical nurses, so-called, or those who have spent no prescribed time in training, or who have pursued no definite course of study.

CLASSIFICATION OF NURSES.

Section 4. In beginning the task of classifying and reducing the number of these varied groups, and defining standards of instruction, the committee agreed on the following main premises:

First, That the good of the public should be the paramount consideration.

Second, That *the system of grading recommended should be such as to include every one who nurses for hire.*

Third, That all who nurse for hire should, for the protection of the public, and for the sake of the welfare of the sick, be required to prepare themselves for such work by a minimum course of instruction and study of the elementary principles of nursing, and that the co-operation of the medical profession and public health officers toward the attainment of this object should be sought for and secured as far as possible.

Fourth, That the system recommended must include provision for supervision by some responsible representative local organization.

Before deciding to submit the recommendations which follow in regard to classification, the committee consulted a large number of hospital superintendents, teachers of nurses, physicians, nurses and laymen, and carefully weighed the various distinctive or qualifying terms which have been suggested, or are in use, such as undergraduate nurse, experienced nurse, practical nurse, licensed nurse, attendant, etc. The following considerations carried most weight when the decision had to be made:

(1) Standard dictionaries define a nurse as "a person who cares for the sick, helpless, or infirm." This definition has been accepted and universally used, without question, for centuries.

(2) The person who does nursing, or gives personal care to the sick as an occupation, will be called a *nurse* by physician, patient, and the public, irrespective of the quality of the work, or of any contrary recommendations which this Association might make, or any other measures which might be used to prevent the free use of the term "nurse."

(3) Even where a course for "trained attendants" has been offered and given, the worker thus trained, when she enters the home, is usually called "Nurse." To insist or recommend that she call herself "attendant" or any other term, when doctor and patient call her "Nurse," can only lead to embarrassment, and to forcing the worker into a false position. It will ultimately help to defeat the objects which it is most desired to accomplish.

(4) Any attempt to restrict the use of the term "Nurse" to registered nurses or highly-skilled graduates, or nurses of registered training schools or hospitals, and to prohibit its use by all others engaged in caring for the sick, cannot fail to lead to the embarrassment of a large number of small and special hospitals, and to add to the difficulties under which their work for the community is carried on.

(5) The same arguments against the application of the term "Nurse" to any but highly-trained workers, could be used in connection with numerous other occupations, such as teacher, doctor, professor, cook, stenographer, etc. The public will not tolerate such restrictions in its use of the English language.

After prolonged discussion it was decided to recommend the classification of all in the various groups mentioned in section 3 into three divisions or groups, to be known as Grades A, B, and C. The terms Registered or Graduate Nurse, Certified Nurse, and Household Nurse, to correspond to the different grades, were decided on after long consideration of every qualifying term which has been used in America, of which the committee had knowledge. So far as it was possible to discover, the term "Certified Nurse" originated with the Albany Guild for the Care of the Sick, some years ago, and is used to designate

a nurse who has had sufficient technical training to make her safe and useful in ordinary cases of illness, but who does not wish to be known as a fully-trained graduate nurse. It is still used by that organization to distinguish the partially or home-trained nurses from the fully-trained hospital graduates employed by that association. It has also been adopted by other organizations to designate a nurse who has had a prescribed course of instruction under supervision, but is not, and does not wish to be known as a fully-trained graduate nurse.

The term "Household Nurse" explains itself, and signifies a nurse who, besides assisting in the care of the sick, assists also with the care of the home in which there is sickness.

Grade A—Registered or Graduate Nurses.—This grade shall include regularly trained hospital graduates who have met the requirements recommended by the American Hospital Association, or who are registered or eligible for registration, in such states and provinces as provide for registration.

Grade B—Certified Nurses.—This grade shall include those who have taken courses of training of not less than one year in special hospitals, or in hospitals which are unable to comply with the standards for complete training fixed by the American Hospital Association in 1909, or who are for other reasons unable to meet the requirements for Grade A, but who have had not less than one year of hospital training.

It shall also include those who have met the theoretical requirements for this grade, and have acquired experience under proper supervision in private homes, for a period of not less than one year and four months, or 68 weeks, during which time not less than twenty different patients have been cared for, including medical and maternity patients.

Note.—Fuller details regarding supervision and regulations relating to this group are under consideration, and remain to be worked out more definitely, before further recommendations are made on this point.

Grade C—Household Nurses.—This grade shall include all nursing for hire who are not eligible for, and not included in, either of the other classes or groups, those who have taken short courses by class instruction or secured private tuition, and also

the very large group of workers who have had no prescribed training, who have been pressed into this form of service by physicians, in order to meet the great demand for this class of helpers. (Note.—The term *"attendant nurse"* is suggested as a possible substitute, if preferred.)

Section 5. REQUIREMENTS AND SUGGESTED CURRICULUM FOR CERTIFIED NURSES.

GRADE B.

Many considerations led the committee to recommend as a curriculum for Certified Nurses the first year course of studies and training recommended by the Special Committee in 1909, with the addition of some instruction in maternity nursing. Chief among these considerations were the following:

(1) The studies outlined should be the foundation studies for either general or special nursing.

(2) The desirability of making it possible for many small and special hospitals which are unable to give a complete training according to the standards of the Association, to give a training which would be recognized as a part of the general plan—a preliminary course or primary training, which might be completed in some other larger institution, or one handling a different class of patients. While under present conditions each institution has its own policy, as regards students from other schools, and controls, or should control, its own admission to its training school, the committee believes that there are ambitious young women who might, for various reasons, enter first for the Grade B course only, who should be encouraged to continue and later enter Grade A, and that many advantages might accrue from such a policy. Inasmuch as some hospitals now give credit for time spent in pursuing *theoretical* studies in nursing in a school or college, so it is believed that credit should be allowed a nurse who has completed in a small (under 25 beds) or special hospital the first year course recommended by the Association. It is expected, of course, that the acceptance or rejection of this suggestion would be a purely optional matter with every school, and that credits would be allowed only after an examination, and after the presentation of suitable testimony as to general standing and efficiency from the school first entered. The nurse who entered for training near

to middle life would probably choose to begin to earn from her nursing on completion of the course for certified nurses. The younger nurse, with ambition to excel, would probably wish to continue he course elsewhere, and should not be debarred from so doing.

It is believed, also, that for home nursing many valuable lessons may be learned by nursing in private homes, which are not possible to be learned in even the best appointed hospitals, and that adaptability to present-day conditions and needs, is more essential to success in this line of work than elaborate surgical technique. The committee wishes to call attention to the fact that the Albany Guild for the Care of the Sick has succeeded in training nurses under its auspices in homes, and in connection with the Guild headquarters, under the supervision of visiting graduate nurse instructors, who have passed satisfactory examinations, and are now registered nurses in New York State, according to the Year Book of that Association.

For these and other reasons, the committee has been led to suggest one year and four months, or 68 weeks, and the satisfactory completion of the theoretical course for certified nurses, as an equivalent for one year of hospital training. It is the conviction of the committee that the promotion of better nursing in middle-class homes demands a recognition of the possibilities of training which are outside of regularly organized hospitals—possibilities which have heretofore been little considered except by commercial organizations.

RECOMMENDATIONS FOR CLASS INSTRUCTION.

Ethics and etiquette of the sickroom	2	hours
Anatomy and physiology	10	"
Personal hygiene	2	"
General hygiene	2	"
Bacteriology—theory	3	"
Sterilization and disinfection	1	"
Medicines and materia medica	6	"
Dietetics—theory	6	"
Practical lessons in invalid cookery and administration of food	6	"

General bedside nursing	20 hours
Fever nursing, including contagion and care of special medical cases	5 "
Maternity nursing	10 "
Care of infants	2 "
Minor operations and accidents in the home, with after care	2 "

It is recommended, for hospitals giving this course, that pupils be admitted for training as far as possible between the months of March and September, so that systematic class instruction may be carried on throughout the school year, and that the annual school term recommended by the American Hospital Association in 1909, of 38 weeks, with not less than two class periods weekly, be accepted for this grade. The committee makes no recommendation as to whether the probation term shall or shall not be included in the year.

Experience having clearly proven that instruction by the lecture method is liable to vary in contents and emphasis with each individual lecturer, and that inexperienced workers or students are unable to grasp the substance of instruction by lecture, in most instances, the committee wishes to especially urge that standard text-books be required to be used by all students and teachers, inasmuch as text-books suitable for each grade are easily obtained.

SUGGESTIONS FOR BEDSIDE INSTRUCTION.

The list of clinics and demonstrations which follow are those recommended for the first year's training by the American Hospital Association in 1909. It is not suggested that these lessons or demonstrations must necessarily be separated from the lessons on general nursing, nor that they shall be taken in the order in which they read, but that they should be included in the class work and bedside teaching during the year, it being considered that, of all teaching, the practical bedside teaching is the most important.

(1) Beds; bedding; bed-making, with and without patient; management of helpless patients; changing beds; bed-making for operative patients; rubber cushions; bed rests; cradles; arrangement of pillows, etc.; substitutes for hospital appliances.

(2) Sweeping; dusting; preparing room for patient; disinfection of bedding; furniture, etc.; care of patient's clothing in wards and private rooms; disinfection of infected clothing.

(3) Care of linen rooms; refrigerators; bathrooms and appliances; sinks; hoppers; bathtubs, etc.

(4) Baths—full sponge, to reduce temperatures; foot baths; vapor baths; hot and cold packs.

(5) Administration of rectal injections, for laxative, nutritive, stimulating, astringent purposes; care of appliances; disinfection of excreta.

(6) Vaginal douches; methods of sterilizing appliances; use and care of catheters; vesical douches; rectal and colonic irrigations.

(7) Local hot and cold applications; making of poultices, fomentations, compresses; methods of application; care of hot-water bottles; uses and care of ice caps and coils.

(8) Chart keeping; methods of recording bedside observations.

(9) Making of bandages—roller, many-tailed, plaster, abdominal, breast, pneumonia jackets.

(10) Methods of applying roller bandages.

(11) Methods of applying other bandages.

(12) Appliances to prepare for ward examinations and dressings; sterilization of ward instruments; nurses' duties during dressings.

(13) Preparation of patients for operation; hand disinfection.

(14) Preparation and care of surgical dressings, sponges, swabs, etc.

(15) Tray setting and food serving; feeding of helpless and delirious patients; management of liquid diet.

(16) Administration of medicines; methods of giving pills, tablets, capsules, powders, oils, fluids; application of plasters, ointments, etc.; use and care of medicine droppers and minim glasses, atomizers, inhalers, hypodermic syringes, etc.; management of inhalations, eye drops, suppositories, etc.

(17) Care of the dead.

(18) Symptomatology—the pulse; correct methods of examining the pulse; volume, tension, rhythm, rate, etc.; effect

of exercise, emotions, baths, drugs, shock and hemorrhage.

(19) The face in disease—the skin; expression, eyes, mouth, teeth, etc.; variations from the normal; care of mouth and teeth; general observations of the body.

(20) Respiration—normal, and in respiratory affections.

(21) Pneumonia—respiration, cough and sputum; crisis and lysis explained and charts shown.

(22) Typhoid fever—face, rose spots, temperature charts, changes in temperature and pulse explained; danger signals; prophylactic measures; methods of managing delirious patients, proper restraint, etc.

(23) Specimens of excreta—urine, sputum, feces, etc.; nurses' duties regarding each; importance and general management.

It is assumed that, in special hospitals, instruction in the management of the special class of patients treated in each special hospital will be given in addition to the studies outlined.

It is further recommended that institutions or organizations offering this course do not advertise to give *diplomas* in nursing, but do distinctly state that only the *first stage of the full nursing course is offered* by the school; also, that the certificate given should clearly state that the candidate has completed *the prescribed course for Certified Nurses and the duration of the course.* It is the conviction of the committee that the first step to a proper distinction in the minds of the public between a nurse who has had a complete training and one who has had a partial, though distinct, training is for hospitals themselves and hospital staffs to clearly observe such distinctions and to recognize their own limitations.

REQUIREMENTS AND SUGGESTED INSTRUCTION FOR HOUSEHOLD NURSES.

GRADE C.

This grade must be recognized as the beginner's grade. It includes the largest number of all the groups in the nursing field, and the most difficult to grade and manage. Investigation and observation have shown that physicians are constantly finding in their practice excellent women who show some fitness

and aptitude for nursing, yet for various reasons are debarred from taking a full course of training. Many physicians have testified that they would gladly insist that these helpers in the sickroom pursue a minimum course of instruction, if local facilities were afforded, and if they could secure such instruction without too great expense and loss of time. This group, more than any other, is exploited by correspondence schools, and many in this group are led to believe that they can, *through correspondence,* secure a standing and training as a nurse equal to that of the hospital graduate, and that the course of instruction offered by correspondence is superior to that given in hospitals. The prices charged each worker for such instruction range from $50 to $100, and upwards.

The committee, after careful study of this phase of the problem, has been led to recommend that a minimum course of four months be offered by local organizations, covering chiefly the methods to be used in common nursing duties, believing that more will be effected in the direction of improvement in household nursing by placing the *minimum* standard of instruction so low that anyone fitted for such work can secure it, than by placing it so high as to be discouraging to this large group of workers. The committee wishes to emphasize that this standard is *a beginning,* and to remind the Association that in the beginning of trained nursing a one-year course in a hospital was considered a complete training, and that the instruction prescribed and recognized as a complete training at that time was substantially that which is here suggested for household nurses. It is hoped, as physicians begin to realize the value of even a minimum course, that the standard can be raised. A great many workers in this group, after completing the beginner's course, should be encouraged to continue their study and efforts to improve, and to qualify as certified nurses.

PERSONAL REQUIREMENTS FOR NURSES IN GRADE C.

A certificate of health.

High moral character.

Sufficient education to read and write and keep intelligent notes of cases.

Recommendations from not less than two responsible citizens (not relatives), one of whom shall be a clergyman.

SUGGESTIONS FOR INSTRUCTION.

Etiquette and ethics of the sickroom, 2 class periods.

Germ theory and principles of asepsis, 3.

Methods of sterilization and disinfection of everyday sickroom utensils, 1.

Household hygiene and management of sickroom, 1.

Personal hygiene, with special reference to avoidance of infection, 3.

Care of bed, bed-making, bed-sores, etc., 1.

Making the best of household materials in sickness, 1.

Personal everyday care of sick, 1.

Special methods of promoting the patient's comfort, 1.

Feeding the sick, 2.

Invalid cookery, 4.

Temperature, pulse and respiration, 2.

Observation of patients and note-taking, 2.

Baths, cleansing, and to reduce fever, 1.

Home treatment—packs, hot and cold; enemata; douches, poultices; cold compresses, hot fomentations; sweat baths; catheterization; care of ice caps, hot-water bottles, etc., 4.

The giving of medicines, 2.

Care and feeding of infants, 2.

Care of sick children, 2.

Common household disinfectants—how to make and use them; precautions, 1.

Practical points on dealing with communicable diseases in the home, 1.

Bandaging, 1.

Household emergencies and minor wounds, 2.

Maternity nursing, 6.

Special medical cases and care of chronic invalids, 4.

Note.—It is suggested that lesson periods be not less than one and one-half hours, and that practical demonstration of correct sickroom methods be included, whenever possible, in every lesson.

Section 6.—ORGANIZATION AND GENERAL CONTROL.

The question of state control of all grades of nursing versus general supervision and control of Grades B and C by responsible representative organizations operating in a city or county

unit, with the probable co-operation of local public health officers, has been carefully considered by the committee, and the advice secured of a large number of interested physicians and others who have had much experience with the problems, successes and failures of state control along other lines. It is the concensus of opinion that any attempt at state control which is not preceded by a widespread and protracted campaign of general education and organization would retard rather than promote the improvements desired; and that at present much greater possibilities lie in developing local Household Nursing Organizations, which will work out the many problems which should be worked out before intelligent legislation is possible.

The committee desires to call the attention of the American Hospital Association to the plans for the care of the sick, which are outlined by the newly-organized Bureau for Organizing Home Care for the Sick,* which exists to assist in the promotion of local organizations for neighborhood co-operation in the general care of sickness in the home. A considerable part of the work of this bureau will consist of investigation and research such as is now going on in several places. A fundamental feature of its work is to start with the home, studying its needs on the case system, and organizing its work and shaping its plans in accordance with the findings. The plans on which such work may be conducted have been given practical test, first in Brattleboro, Vermont, and have been adopted wholly or in part by organizations doing similar work in Boston and elsewhere in New England. The methods that have been evolved by an experiment extending over several years seem to be equally applicable to large and small communities. The object of a local association of this character may be briefly stated to be "to do what is possible to supply those needs in sickness that are not now properly covered by hospital service, by visiting nurses, or by unorganized private nursing. It aims "to become a medium of exchange between those who need help and those who can give help in sickness or emergency, and to serve the growing needs of the community."

* The Bureau for Organizing Home Care for the Sick has its present headquarters at 60 State St., Boston.

The plans include the establishment of a Household Nursing Office, which will serve as a centre for a given territory and a clearing-house for several grades and kinds of workers, who should be provided to meet a need in time of sickness in middle-class homes. Such an organization does not attempt to dispense charity, but does attempt to furnish at cost such service as is needed. It aims to furnish, when necessary, a graduate nurse for service through the acute stage of a disease, to replace her by a less skilled worker, when highly skilled care is no longer needed, so that the valuable services of the fully-trained nurse may be more generally utilized where highly skilled nursing is needed, but is not wasted where others less skilled will fully meet the needs.

The office is managed on a business basis, and is in charge of a graduate nurse, who provides for the supervision of such household nurses and other helpers as are needed in sickness. The office has on its lists names and addresses of persons who are free to go to a home and serve by the week, those who can serve for a day or part of a day, those who do cooking or washing, or are able to care for children, and various other classes of helpers who are able to fill gaps in homes in which sickness has entered. It does not find the money to pay these workers, but endeavors to furnish them at rates which the family or friends can meet.

The putting into practice of such a plan involves a number of questions which require the most careful consideration, in order to reach a proper solution. Your committee suggests, therefore, that the best method of promoting a wise and proper plan of organization is to develop as soon as practicable a few more centres which will serve as experiment stations, under the best possible expert advice, both for the nursing and medical side and for the sociological and business side. This would make possible the increase of practical knowledge with which to solve doubtful questions, and would establish as soon as possible sound, practical working standards relating to this particular department of humanitarian work.

Experience gained in the household nursing centres which have been developed, goes to show that, under a proper business-like plan of organization for the care of the sick in the home, it

is possible to provide a skilled graduate nurse for supervisory, educational, and emergency work, and the services of a household nurse for continuous nursing in homes, at a cost of from $8 to $16 weekly. In maternity nursing in the home, this sum includes pre-natal care and supervision, the services of a graduate nurse to assist at the birth and for the first nursing care of mother and baby; daily calls from the graduate nurse as long as necessary, and the continuous service of a household nurse, who receives bedside instruction from the graduate nurse. In Brattleboro, Vermont, the average cost for two weeks of this service, in twenty-five routine cases which were averaged, was stated to be about $12 per week in 1911.

The organization needed to provide such service does not differ materially from the organization for a small hospital, where a representative board is in general control, a skilled graduate nurse is in charge of the hospital and of the details of the work, and where the nursing in the hospital is done, for the most part, by pupil nurses, with graduate nurses for the places requiring special skill and experience.

It is the belief of the committee that intelligent expansion of hospital and nursing service in any community, and also the promotion of economy and efficiency in hospital management, demand that a broad, statesmanlike view be taken of the entire problem relating to the care of the sick; that a careful study be made of the existing facilities for meeting present-day needs, and of other facilities which should be brought into existence in order to adequately and efficiently and economically care for all classes of sick in the different communities; also that some definite plans for co-operation in administration be worked out by the various organizations devoted to the care of the sick. Such questions as, "Who should go to a hospital?" "Who should be cared for at home?" and "How to provide the most efficient care in each case?" so that the best results to the individual, the family and home and community may be obtained, are large questions which cannot be decided satisfactorily by any one group of workers, but which require the combined wisdom of several classes of workers in the field of philanthropy. Whether it is wise to ask for public funds or private capital to provide hospital accommodation for patients who could be as efficiently

and safely cared for at home as in a hospital, and for the same rate, or less, given reasonable provision for meeting the needs of the patient and home, is an important and unsettled question relating to hospital and home economics, which has a definite bearing on the grading and organization of nurses, on how many kinds of nurses should be trained, and how they should be trained. These questions suggest the magnitude and complexity of the problem of the development of nursing facilities in relation to the needs of each community, and of the responsibilities of hospitals in connection with the problem.

Section 7.—CO-OPERATION WITH PHYSICIANS AND PUBLIC HEALTH OFFICERS.

While it is the hope of the committee and of many others consulted, that legislation may ultimately be enacted which will make it essential for all who nurse for hire to make such preparation as will enable them to comply with a minimum requirement before beginning to nurse, or during a specified time while continuing to nurse; and while it is believed that an enlightened public opinion will, in course of time, demand that such preparation be made, and that such legislation, when backed by an intelligent public opinion, will greatly assist in solving the problem of the grading of nurses, and of nursing in homes of moderate means, *the committee wishes to emphasize as of greater present importance, the securing of the active co-operation of the medical profession in any constructive effort undertaken to meet needs which so closely concern physicians.* It cannot be too strongly emphasized that if a practical working solution of the grading of nurses, and of how best to promote economy and efficiency in household nursing, is to be reached, it must be done with the sanction and co-operation of the medical profession as represented in local communities, and that local medical health officers and boards can render official service to the cause, which is of great value.

There is great reason to believe that with the co-operation of the medical profession and public health officers in a given community, and the adoption of the plans and standards herein outlined, many of the abuses which have flourished in the American nursing field, may be gradually abolished. Many of

these abuses, notably, the custom which has grown up in many places of making exorbitant charges for totally untrained and unskilled nursing, exist because of the lack of any responsible local organization, which, acting on the principle of "this one thing I do," will devote itself to meeting such needs economically and efficiently.

Section 8.—SPECIAL RECOMMENDATIONS.

(1) The enormous development of tuberculosis hospitals and sanitaria, in recent years, the difficulty of securing hospital graduates in sufficient numbers for routine work in such institutions, and the fact that comparatively few general hospitals provide for adequate instruction and experience in this branch of nursing, have led to the introduction of the training of nurses in many such institutions, in order to provide intelligent care for those sick with tuberculosis. In view of this fact, the committee suggests that effort be made to bring to the attention of the authorities of such institutions, the recommendations contained in this report regarding the one year course for certified nurses. It is expected that a fully trained graduate nurse will always be employed to supervise the nursing in such institutions, and assist in the training of those who enter for the course.

(2) Whereas maternity nursing furnishes, and will continue to furnish, a large part of the demand for certified and household nurses, the committee desires to call special attention to this need, and to urge that in all hospitals or schools giving the one year course, special emphasis be placed on instruction in maternity nursing, with special reference to average home conditions, and that as far as possible, community facilities for gaining experience with this class of patients be utilized, under proper supervision, as is now done in connection with medical students.

(3) In view of the importance of the work, and of the diverse factors to be considered, the committee suggests that another year, at least, should be given to the study of the details regarding supervision, organization, and extension of facilities for providing efficient and economical service to the sick in homes of moderate means, before submitting fuller recommendations, believing that, in the constructive work which is needed,

the additional time and experience will undoubtedly result in a broader outlook, clearer vision, and wiser planning.

IN CONCLUSION.

In the first decade of the twentieth century there was witnessed in the United States and Canada a degree of activity in hospital building and general expansion of institutions for the care of the sick that has been unprecedented in the history of the world. The committee expresses the hope that in the second decade of the century there may be seen a corresponding activity in the study of community needs, and constructive effort to establish an efficient system of nursing service in homes of families of moderate means; that the members of the American Hospital Association, to whom great responsibilities have been entrusted, may have a large part in determining the character and quality of such nursing, and in the general development along sane, practical, helpful lines, of this form of social service so closely related to hospital work.

The committee on grading of nurses has endeavored to take a broad view of the field, and to square its recommendations with conditions and needs as they are, with the highest good of all the institutions and individuals, and different classes of people concerned, as its chief objective point. It submits this report, asking that it be not considered as a finished plan, but rather as a beginning, a contribution toward the effective working out of a complex sociological problem, which concerns a large part of the population in every city, state, and province, a problem which cannot properly be divorced from the question of how best to promote economy and efficiency in hospital management, nor from hospital development in America.

Signed:

CHARLOTTE A. AIKENS,
EMMA A. ANDERSON,
IDA M. BARRETT,
R. BRUCE SMITH, M.D.,
P. E. TRUESDALE, M.D.

THE GIST OF THE RECOMMENDATIONS.

A system of grading similar to that which exists in the teaching profession.

The various classes or groups of nurses to be reduced as rapidly as possible to three—registered or graduate nurses, certified nurses, and household nurses—grades A, B, and C, with a recognized standard of instruction for each class, as is the case with teachers.

The foundation studies in bedside nursing and allied subjects, usually covered in the first year, to be the same in all hospitals, irrespective of size, or of class of patients.

Grade B, or certified nurses, to be trained in small hospitals of under 25 beds, and in special hospitals, sanitaria, convalescent homes, etc.

That, as rapidly as possible, city or county organizations and centres be brought into existence to be devoted to the specific purpose of supplying efficient nursing to middle-class families and to standardizing household nursing.

That a fully trained hospital graduate nurse be in charge of the details of such nursing in each centre under the supervision and direction of a representative board, as is the case in a small hospital serving a community, or a visiting nurse centre.

That a serious effort be made, through organization, to effect a better distribution of hospital graduate nurses, and to secure the more general use of such nurses in acute cases, the ultimate aim to be to fit the nurse to the needs of the case, providing a graduate nurse where a high degree of skill is needed, and a less skilled and less expensive worker where such will fully meet the need.

A recognized minimum standard of instruction in practical nursing to be required of all who nurse for hire, so soon as local facilities for household nurses to acquire such instruction be provided.

That active effort be made to secure the co-operation of the members of the medical profession and of public health officers, in establishing an efficient system of household nursing for families of moderate means in each community.

That, in each institution and training centre, a course of instruction in maternity nursing be provided for.

That because of the importance and complexity of the problems involved in getting a businesslike system of household nursing established, the Association should continue the study,

for another year at least, by the continuation of the committee or the appointment of a special committee on household nursing.

That the special committee on household nursing be authorized to promote the adoption of the recommendations of this Association, and to co-operate, as may be desirable and necessary, with other organizations in developing household nursing centres, which will serve as demonstration stations in which the medical, economic, nursing and sociological aspects may be carefully studied, to the end that the most efficient system possible may be established.

AMERICAN HOSPITAL ASSOCIATION

THE 15th Annual Conference of the American Hospital Association was held in Boston, August 26-29.

This was one of the most interesting and best-attended hospital conventions ever held.

The address of the President was well received. We hope to publish it in full in our October number.

Miss M. M. Moore, of Jackson City Hospital, Mich., read a paper entitled "Ambulance Service for Small Hospitals." The essayist told of a fifty-bed hospital, with half-pay patients, using a horse ambulance maintained by an appropriation from the city, the janitor acting as driver, and an orderly going along—an interne as well, in cases of accident. Though imperfect, this gave greater satisfaction than the present arrangement, whereby a private concern furnishes an auto-ambulance, for the service of which the city pays for each patient brought to the hospital. On leaving the hospital, the paying patient pays for his transportation home—much more than the city pays for his carriage to the hospital. For non-paying patients, the price home is the same as that to the hospital, which the city pays. This does not appear to be fair to the paying patients, who complain. An advantage it has over the older methods is that it does not take any of the officials away from the hospital. The comparative cost for one year was: Horse ambulance, $442; auto, $694. The auto is speedier, more convenient, and more comfortable.

Dr. Herbert Hall, of Marblehead, Mass., read a paper on "Hospital Workshops for Handicapped Labor." The out-patient workshop is a new hospital department of specialized work. It is established for chronic out-patients. It affords protection to the hospital by preventing a return of the patients to the hospital as a result of subsequent breakdown from unsuitable employment. Existing industries are adopted, and work found which the patient enjoys doing. This is not difficult to ascertain. The therapeutic effects of such a new environment are wonderful. Then, too, the economic possibilities must not be forgotten. The work at Marblehead was at first not self-sustaining; now it is

and paying. The possibilities of handicapped labor are immense. Hand-craft has been one of the main lines of endeavor—weaving, basket-making, pottery and the like; but many other branches of industry may be followed with much success. This work should appeal to hospital and asylum authorities, and there should be the widest co-operation among them.

Richard M. Bradley, of Boston, the pioneer in the establishment of Household Bureaus for the care of the family when sickness invades the home, read a paper on the subject.

CALL ON HOSPITALS TO ADJUST THEMSELVES TO OUTSIDE WORK.

There is a call for the hospital to adjust itself efficiently to kindred outside work, and to take its proper part in a comprehensive system for the care of the sick and helpless, covering the whole ground and including the homes of the people.

RELATIVE IMPORTANCE OF OUTSIDE WORK FOR THE SICK.

The outside work in the homes, though scattered, embraces an enormous proportion of the serious cases, and is of vital importance.

DEFECTS OF OUTSIDE NURSING.

It is not being well done; on the contrary, so far as concerns a large portion of the needs of the people, it is being done worse than a generation ago.

It has suffered from lack of organization. That lack can be supplied by the organization of local units for home service in sickness.

PRINCIPLES OF ORGANIZATION TO CURE THESE DEFECTS.

Principles of such organization.

Study the actual needs of individual families in sickness, and organize to supply them.

Establish a centre where those needs can be made known.

Get hold of all the responsible workers, skilled and unskilled, employing some on salary and getting the call addresses of the others.

Make use of these workers in co-ordination, using the skilled to supervise and direct the unskilled, thus meeting all needs with the greatest economy and efficiency.

Apply sound economic principles by meeting the needs of the independent classes on a business, not on a charitable, basis.

EFFECT OF SUCH ORGANIZATION ON THE HOSPITAL'S OWN WORK FOR THE SICK.

The effect of this organization, when established, on the effectiveness of hospital work.

It enables the hospitals to get the right cases at the right time.

It saves the hospital from taking cases that do not need hospital treatment, but cannot be cared for at home without the help of proper outside organization.

It enables the hospitals to send patients home under good conditions, to make room for patients who need the hospital.

Effect of proper outside organization on the educational work of the hospital:

It promises a more satisfactory position in the community for the graduate, and more satisfactory ends for the student to have in view while getting her training.

It promises that she will no longer be largely confined to a choice between work among the well-to-day in private nursing, or work among dependents in charity nursing, but that she will have a field covering the whole community, where her special ability and training will be made to count to the fullest extent.

It offers relief from many vexed questions as to grading and naming nurses, by providing an efficient means for putting the right woman on the right case.

It promises to bring more good material into the training schools by means of better working conditions for graduates, and a better touch on those homes from which most of the best nurses come.

Dr. John A. Hornsby presented a paper, an abstract of which follows:

Shakespeare says: "He will shoot higher who aims at the moon, than he who threatens a tree." But there must be a target, either the moon or the tree, if one is to hit anything at all. So there must be a target in hospital service—something definite to shoot at. It is proposed in this paper that work shall be done to give us a high aim, by the establishment of some high ideals. This can be done, not in one's office, but out in the field. The future course can be set by guide-lines from the past and present.

We must know what is being accomplished now before we can set the stakes for the future.

Mr. E. P. Haworth, Superintendent of the Willons Maternity Sanitarium, read a paper on "What the American Hospital Association Can Do for the Hospitals of America."

He said that in taking up certain new lines of work and broadening its field of opportunity, the Association can very materially help the hospitals of America. The essayist recommends the appointment of a paid permanent Secretary, with a central headquarters. To support such an office and officer, the membership fee to the Association should be increased; the membership should be extended to include other members of the hospital staffs in addition to the superintendent, and the next ranking officer. The Association should publish its own official organ; the secretaryship might be endowed.

Mr. Haworth advocated the formation of State or sectional hospital organizations—daughter associations. They would be of great value to many hospitals. America was so large that the superintendents in the more remote West, South and North-west found it impossible to attend the meetings of the big Association by reason of the great distance.

The essayist recommends the establishment of an annual institute for the training and teaching of executive officers—a sort of Chautauqua, to be held either before or after the regular meeting of the Association.

"How the Small Hospital May Be Made Self-Supporting." This was the title of a paper read by Mr. G. W. Olson, Superintendent of the Swedish Hospital, Minneapolis. We ought to take a business view of hospital work. Too often were hospitals (public or private) looked upon as poor business enterprises. They neither attract capital nor command credit. Why should hospital service be less valued than hotel service? The development of the modern hospital from the primitive Krakenhaus attached to some almshouse has been remarkable along all lines except the business side. People still cling to the theory that they have a right to enter the hospital without petition, and leave it without paying. States and municipalities were doing much to keep this theory alive by their erection of gigantic establishments for the care of the sick, often without discrimination as to the

relative poverty of patients. This was unfair to the voluntary or semi-public hospital; these found it difficult to make collections. The taxpayer who builds and maintains the great free institutions, but by his social and economic status is barred from their use, finds it galling when he must go to the voluntary hospital and pay for service which the reckless, the thriftless and luckless have thrust upon them free of charge at the public institutions.

In spite of these handicaps, the semi-public general hospital may be so conducted that it will support itself from the earnings received in return for its services to its patrons. A hospital should be made to be self-supporting from its foundation, and should be able to provide for its growing wants. It is difficult for a hospital founded on great benefactions and showered with gifts in its infancy to attain self-support. Too much will be expected of it in the way of free service, and it will find difficulty in enforcing rates from those able to pay. Better to start with a moderate amount of donated capital—in the form of fees paid for membership in a hospital association, organized for the purpose of building and conducting the institution. The necessary additional capital may be borrowed on the notes of the trustees, who should be business men of experience and responsibility. The hospital can then proceed to do business unhampered by any strings upon its funds. It can frankly demand a remuneration for its services; and if its rates are made, not by guess, but after thorough investigation as to the cost of the service which the hospital has to sell, then it can expect to meet its just obligations, pay interest on its loans, and provide a sinking fund to take up the principal of these loans in the course of time. It is possible even that a reasonable dividend may be yielded, like any other well-managed business. This dividend should then be disbursed in the form of free work for the worthy poor, who may require hospital service.

Paying patients who are unable, through protracted illness, to keep up payments, should be assisted from charity funds which the hospital should establish from its surplus earnings. Further charity and social service work should be done through the hospital, but not directly by it. Too much spreading out in these directions is disastrous to the economic success of the

hospital. Auxiliary societies may, if properly managed, look after needy cases and raise funds for their care, as well as assist them after leaving the hospital.

Dr. W. L. Babcock presented the report of the committee appointed to outline a standard course in hospital administration. We shall publish this in full in a future number.

Mr. Geo. F. Clover presented the report of the committee to memorialize Congress to place hospital instruments on the free list. Mr. Clover prepared an excellent brief—which we hope to publish in full—which he submitted to the Committee on Ways and Means of the House of Representatives. He also appeared before the Committee personally and made a plea to permit hospitals to import free of duty medical and surgical instruments, appliances, apparatus (including Roentgen-ray plates), utensils, and chemical and pharmaceutical preparations.

The opposition on the part of the surgical instrument manufacturers and others to the petition was very intense. The statements made by some of the gentlemen in opposition were misleading, while others were erroneous. In contradiction to these statements, a brief was filed.

After learning that it was not thought possible to grant the petition, Mr. Clover urged the Committee to place surgical instruments and appliances on the free list, without special regard to hospitals, or, if this could not be done, to lower the rate of tariff as much as possible. He was actuated to this by understanding that it was considered by the Committee inexpedient to grant special privileges to the hospitals along this line, because: (1) It would make the operation of the law exceedingly difficult; and (2) there was a strong feeling that some hospitals would abuse the privilege.

The Committee on Ways and Means did lower the duty on hospital instruments from 40-45 per cent. *ad valorem* to 25 per cent.; or perhaps to 20 per cent. On scissors the rate will be 30 per cent.

Mr. Clover recommends that a repeated effort be made to obtain special exemption, with a view of finally getting these articles on the free list.

(To be continued in our October Number.)

Society Proceedings

REPORT OF THE HOSPITAL SECTION OF THE AMERICAN MEDICAL ASSOCIATION

By J. N. E. Brown, M.D., Medical Superintendent, Detroit General Hospital.

The second meeting of the Hospital Section of the sixty-fourth annual session of the American Medical Association was a success. The Section was organized in Los Angeles two years ago, and held its first meeting at Atlantic City last year. Dr. H. B. Howard, of Boston, presided at the Minneapolis meeting; J. A. Hornsby was secretary, and William H. Ward, of Minneapolis, acted as stenographer. Edward Stevens, hospital architect, read a paper on "The Trend of European Architecture." Richard Schmidt, who also is doing hospital work, and who has recently, in conjunction with Dr. Hornsby, published a book on hospitals, read a paper on "The Architecture of the Great Charity Hospital"; and L. A. Lamoreaux, Minneapolis, gave a talk on general hospital construction.

Other papers were: "Equipment of a Small Hospital"; "Making Over a Dwelling House"; "Selection of Hospital Help Under Civil Service Rules"; "Municipal Hospitals and Their Relation to the Community"; "Hospital and Asylum Workshops"; "Some Possibilities of Handicapped Labor," by Herbert Hall, Marblehead, Mass.; "Possibilities in the Routine Practice of a Small Hospital," by Herbert Cole, of Bogalusa, La.; "The Psychopathic Hospital Idea," by E. E. Southard, Boston; "Factors Influencing Hospital Costs," Thos. Howell; "Report on the Campaign for the Standardization and Classification of Hospitals," by Dr. H. M. Hurd; "Efficiency in Hospital Nursing," W. Gilman Thompson, New York; "The Trained Nurse of the Future," R. O. Beard; "The Nursing Situation as It Is To-day," Joseph B. Howland, Boston.

Dr. Howard, in his presidential address, spoke on the value of the Hospital Section of the American Medical Association in disseminating knowledge that would improve methods of hospital construction and management. He stated that too much

emphasis cannot be placed on the treatment of the patient by all hospital officials. This was liable to be forgotten by the routinist or the over-zealous scientific hospital worker. The care of the patient should be prompt, scientific and courteous. The essayist remembered the time when the out-patient suffering from tuberculosis was casually examined, given a prescription of cod liver oil and sent away. How different the treatment accorded such a patient to-day. The case is investigated; provision made for his sleeping out-of-doors, instruction given to himself and family as to preventive precautions.

Laboratory methods, continued the president, were playing an important part in the work of the hospital. Prejudices of laymen against spending money on this department were disappearing, and a friendly attitude was developing. There will be no objection to scientific investigations of the case if the patient is well looked after. We should try to see ourselves as others see us. Medical schools should be simply used to teach what the scientific departments of the hospital proved to be true. Where money was appropriated for hospital purposes the whole amount should not be used for building. An amount should be reserved to run it. If well managed, philanthropists, impressed with the usefulness of the institution, would furnish plenty of money for legitimate expenses. Public opinion was being rapidly educated as to the advantage of the hospital over the home in case of sickness—the care is better, and hence better chance of recovery. So the usefulness of the physician is multiplied. In order that the doctor may handle our sick in a progressive manner, the building of hospitals must keep pace with the community. German communities are much further advanced than American in this particular line. Their insurance laws provide for the care of sick laborers and servants in the various hospitals built by the State. Those hospitals in the suburbs of Berlin may stand as models for cities of much larger size in this country. Pennsylvania is the only State which has ever given this aid. Three years ago Dr. Howard recommended that steps be taken to appoint inspectors for general hospitals throughout this country. One of the best steps that could be taken would be to appoint such inspectors, either State or national. It

would help to standardize hospitals and do away with many abuses.

The President reiterated this point: Everything we do, all policies we adopt, should be looked at from this standard—will this make for the good of the patient?

The adoption of such an attitude will attract all the sick to the hospitals, and thus conserve the energy of the physicians and make that energy more efficient.

In his paper on the trend of European hospital architecture, Mr. Stevens began by calling attention to the rapid progress which was being made in medicine and surgery and the necessary pace in the study of hospital architecture necessary to keep abreast of the times. The essayist confined himself largely to a discussion of the ward unit, which was the keynote to the whole hospital. Here the patient lives, eats, sleeps, and spends his weary hours of convalescence. Therefore we should try to build these units as comfortable as possible—away from noise and with plenty of fresh air and sunshine. The great point to remember is to make provision for the best care of the patient. Mr. Stevens threw on the screen pictures of some of the new European hospitals he had recently visited. The first shown was Barnbeck, Hamburg, designed by Ruppel. It consisted of 44 buildings and contained 1,500 beds; cost, 9,800,000 marks; 3,000,000 marks for equipment; $2,200 per bed. The cost would be considerably more were it built in America. Buildings not connected, except the medical and the surgical. Entertainment hall and church in one. Largest number of beds in any ward is 16. Airing balconies and toilets remote from the ward. A laboratory and surgical dressing room were convenient, likewise a day room. Pavilions two storeys in height. Rooms for nurses' quarters. Two operating rooms only.

The next hospital visited was the Rigs at Copenhagen. The ward unit was divided into eight sections by means of stationary screens running partially across each half of the ward. Beds were placed with heads to the screen, and thus patients need not look at the window light constantly, as is the case usually. Air cut-offs at each end of the ward separated the service rooms from the ward proper. Directly in the mid-ward are two rooms—one

for isolation purposes, the other for dressings. Mr. Stevens is reproducing this ward at Bridgeport.

A picture was then shown of Bisfrebjerg, Copenhagen. Site covers 51 acres; ideal; 46 buildings; two to three storeys; isolated above ground, but connected by underground corridors. The six surgical buildings are connected above ground. The vistas between the series of buildings were very beautiful. The patients' wards and rooms are along the south side and ends of a long corridor. Day room on south at centre and service rooms (utility rooms and water closets) in pairs on the north side at about the junction of each third of the corridor. Airing balconies are off the wards.

Mr. Stevens then showed the Munich Schwabing Hospital, constructed by Shachner, which presents, in his opinion, the best German planning. The surgical buildings group with the operating house, and the medical with the bath house, which is one of the most complete in Europe. There are 12 beds in the ward unit, and all wards face south. Good opportunity for getting patients on the balconies and gardens. Utilities on the north. Day-room on the south. The admitting unit is especially good.

Hospitals in Germany are built and supported by the Government. In America, where most hospitals are private institutions and money for construction insufficient, architects are required to economize and make insufficient provision for the service of the patients. However, more and more were they being allowed to add laboratories, sink rooms, and design equipment at the time of making drawings.

Mr. Stevens then showed several new American ward units—the Detroit General, the Cincinnati, the Harper, Detroit, and the Peter Bent Brigham Hospital, Boston. The Bent Brigham Hospital makes fine provision for sunlight and fresh air, and for quick and quiet service. Staircases are directly off the main corridor. The first floor contains two large wards of fourteen and eight beds. Two isolation rooms. The diet kitchen and duty rooms are opposite the main ward—across the corridors. Upstairs there is a large ward and two isolation rooms, and lots of outdoor space, which is on top of the lower storey. The third storey is a complete open-air ward.

In the new City Hospital, Cincinnati, the utility, bath and

toilet rooms are grouped. The entrance to the service kitchen is direct from the elevator. A dining room is provided for convalescents.

The ward is a long one, containing 24 beds, with several isolation rooms.

The Detroit General has the usual long ward, but containing 16 beds, with three isolation rooms, one of which will hold two beds. Next the ward on the other side of the corridor from the isolation rooms is the utility room, then the linen, the bath and diet rooms. Beyond a corridor connecting the pavilions is a small laboratory and a room for dressings.

Harper Hospital, Detroit, uses the first three storeys of its new pavilion for private patients. In these three storeys the service rooms are grouped in the centre. Cross corridors for light and air are provided. There are ample dressing rooms and rooms for cut flowers. Spacious solariums occupy the south end of the ward. In the upper three storeys for public ward patients the toilets are provided at the distal end of the ward; the utility rooms at the proximal end are exceptionally large.

In the new St. Luke's addition at Jacksonville, planned by Mr. Stevens (as was the Harper, Detroit), the main ward has six beds. The diet and duty rooms are commodious and handy to the ward. There is a private ward and a roof ward.

At Youngstown, Ohio, the ward unit contains ten beds. The utility room is centrally placed. At Bridgeport a maternity pavilion is being erected which has a ward unit built on the principle of the Rigs Hospital, Copenhagen, described above—16 beds in four groups. The children's ward contains 18 beds, with partitions of glass.

Reverting from the pictures to his paper, the essayist stated that two things should be kept uppermost in mind in planning the unit: the comfort of the patients and the accessibility of service. The wards should not be overcrowded, 1,200 cubic feet of air space being required. Sunlight (with provision for protection from it when necessary) and fresh air were essential. The air should be heated in winter—not roasted. The ward should be well ventilated throughout the twenty-four hours. The patients should have some privacy and a place in which to hide their household goods which have come with them. The lighting

by day and night should be specially and carefully studied. It should be shielded at night—obscure enough so as not to necessarily waken the patient. No direct ceiling light should be used. Reflected light better. Bedside light needed. Floors should be resilient. Linoleum has proved successful. The color of the walls should be some warm shade with a panel or stencil. A few simple pictures. Care should be taken with the hardware. The click of a latch may waken a patient. This can be eliminated by the use of a check and a spring. Nurses' calls should be silent by means of signal lights. Comfortable beds should be provided with large castors for wheeling into the open air. Comfortable chairs and tables should be provided.

As to accessibility of service, the most important thing was the kitchen. It should be of sufficient size to admit nurses and maids. There should be facilities for light cooking and for keeping the food warm or cold, the cleansing of china, and the convenient laying of trays. This service should be removed from proximity to the patients' rooms. The general utility rooms, with the hopper incinerator, should also be out of reach of the patients' hearing. This room may adjoin the nurses' room. A small laboratory, a dressing room on the surgical side, properly equipped, necessary toilets, and (in the private ward section) a room for cut flowers. Wash basins should be placed in all private rooms, and drinking fountains convenient. Eliminate corners. Make doors wide enough for beds and protect the jambs with metal angles.

Architect Smith, of Chicago, followed Architect Stevens, of Boston. The largest hospitals should be erected at the smallest cost compatible with efficiency, and constructed with a view to conserving the energy of nurses and physicians.

The administration building is the gateway to the institution. It contains rooms for officers, who give out information and do business with the outside world. Then come the admission building, the dispensary and outdoor department. In the admission department there should be provided clothes lockers, clothing sterilizers of steam machinery, demanding the care of an expert. There dressings of all sorts may be sterilized. The whole sterilizing plant should be in the hands of people who do nothing else. The work will be done more satisfactorily, eco-

nomically and methodically. Stores of all sorts may be received in this building and subsequently distributed to all parts of the institution. The storekeeper's office should be at some central point, as he is part of the business administration. It should be near the administration building.

Good food should be properly, quickly and intelligently served—hot; and food intended to be served cold should reach the patient cold. Storage should be at a central point; ice, milk, vegetables, as well as medical and surgical supplies. It will add materially to economical administration if the kitchen and serving building are near by. In many places they have steam and electric trains to carry food from the kitchen to the serving rooms. While these trains are economical, they are not very satisfactory from the standpoint of the patient. You can't get the food in as palatable condition to the patient as when the kitchen is closer to the wards.

In the pathology department there are the ice-boxes by the autopsy room. There should be good light, a proper temperature maintained, and good ventilation. The chapel must not be forgotten. As many cases must pass on to the coroner, a room for inquests should be thought of. The laboratory should be in direct connection. Small auxiliary laboratories should be provided in the ward units for quick examinations of urine, blood, blood pressure. The central laboratory should afford easy access to all parts of the institution. Vaccines are kept in the refrigerators of the laboratory. The autogenous vaccines may be made in this building. The technique of preparation is most exacting. Serums may also be made and dispensed from here for diphtheria, meningitis, etc. So we see how necessary that this building should be placed centrally. If there is a school, the lecture rooms should be central, too. Small clinic rooms should be a part of the ward unit. The surgical operating department should also be centrally located. Departments for children, gynecology, obstetrics, genito-urinary, infectious diseases, tuberculosis (including bones, joints, intestines), nearly all supply their quota to the operating room. The central location makes for economy, and the transportation is not trying to the patient. Recovery rooms should be provided in such a case. Transportation tunnels may connect the basements of each building, and

may carry the pipes for physical service. They should be 15 feet wide and 7 feet high, made of reinforced concrete (including wall and roof), with hooks and hangers for fluing pipes, being accessible for repairs and renewals. The walls can be made waterproof and covered with white enamel or tile. Ventilation may be provided by running the tunnel a few feet above the grade and putting in windows.

Necessary elevators should be provided in every building—hydraulic type. The upkeep is very low.

Water, steam, electricity, refrigeration, etc., can be conveyed a considerable distance with little loss of efficiency. Cover pipes well, so the power plant may be located on the outskirts, where the noise of operation will not disturb the patients. The laundry may be a part of the power plant; it should be under the control and operation of the engineering department. Soiled linen in canvas bags is easily transported a considerable distance by efficient and easy-running trucks. The garbage incinerator may be connected with the chimney stack. Many instal incinerators in the sink rooms. This system is growing in favor.

Mr. Schmidt then showed some interesting pictures of the Cook County Hospital, now under construction, and of several European hospitals.

Architects Stevens and Schmidt were followed by Architect Lamoreaux, of Minneapolis. Starting with the old hospitals, construction followed the same line for centuries, and to-day they are following along the same line that they have been working on for the last 160 years. New hospitals are being built, but these are mostly in the same line of thought and development followed during the past hundred years. Our country, the United States, is noted for its advancement in buildings pertaining to business, and we are the first country in office buildings. New York City is noted for its skyscrapers and sky line.

The speaker had visited, with Dr. Collins, many of the contagious hospitals of the United States. There were a few good ones—very exceptional. They have not had the same attention, care and money placed in them as has (proportionally) been given to the general hospitals. For many of his ideas the speaker was indebted to superintendents of hospitals—Hornsby, of Chicago; Bliss, of Boston; Richardson, of Providence, and

Wilson, of New York. In selecting the best contagious hospital he would select the Measles Hospital of New York City. It is 125 feet long and six or seven storeys in height. It has more of the modern reforms than anything he had seen—conveniences for the isolation of patients—wards convenient for the treatment of patients—cubicles, solariums, porches, splendidly lighted rooms, and handsome buildings. All the rest were developed on the old line—scattered all over a seven to ten-acre lot, as is done in Germany. Some cover acres, including 40 to 50 two-storey buildings, connected by underground corridors. This entails a large heating plant, with the use of much fuel; one-third of the building taken up for something which is absolutely no good—that is, basement. They can, of course, store a few mattresses down there. Nine-tenths of the basements are no good—better without them. One-third the cost of building goes into basement A large portion goes into covering these buildings with roofs, which are unnecessary. We also get an unusually large amount of outside wall. We find in Germany and in this country as well that the cost of these institutions runs up to $2,000 to $2,500 per patient. That is ridiculous and unnecessary. The speaker would consider one square of ground sufficient to build a municipal hospital and a contagious hospital upon—a hospital for 2,000 patients. He would divide the block into two halves. He would so locate the building that the sun would reach all rooms forenoon and afternoon—the axis of the building being on the north and south line. On one-half of the block Mr. Lamoreaux would erect a general hospital and a contagious building on the other half. Between these two he would place the power plant, the kitchen and the laundry. He would build according to the New York style—two, four, six storeys high, making the walls strong, so that as the institution developed storeys may be added —twelve to sixteen if necessary. There was no reason why a sixteen-storey hospital would not be one of the finest institutions a city could possibly have. In 15 or 20 seconds by elevator one could reach any floor. Separation of classes of cases would be easy. Such a building would get good light and pure air, away from the dust. The size of the lawn could thus be increased and utilized for convalescents. This was a future for hospitals which had hardly been thought of in this country.

Mr. Lamoreaux is planning the City Contagious Hospital, to hold 1,000 patients. Two hundred and fifty thousand dollars has been appropriated. He will erect a T-shaped building, with an open-air corridor between each section. In one section of the T there will be nurses' sleeping rooms on each floor. Two elevators will be provided. Each has a frame by itself. One elevator runs up through the different floors and connects with an outdoor corridor. The next section of the T will be devoted to private rooms and an observation room. Each private room has a separate bath and constructed in suites. Dutch doors will be provided, *i.e.*, doors cut in two in the centre, the top half opening independent of the lower. This allows the lower half to be closed and will keep a child patient in the room. It allows free circulation of air and opportunity for observation by the nurses. Next this Dutch door will be a plate glass occupying the balance and the front of the observation room. This allows the nurses to see what is going on in the room, and makes the room more cheerful. The intention is to treat the patients the same as they are treated in the cubicle hospitals. A lavatory is conveniently placed at the door, so that the nurse can wash going out. It has a high faucet with a spray, so that the arms can be washed at the same time as the hands, operated by a foot pedal. The latch of the door is operated by the elbow, and adjacent to the door is a space for hanging gowns. At the opposite side of the room there will be a water closet supported by a marble slab; across the front a curtain may be drawn and door hung. In these observation rooms a patient may be kept indefinitely without going into other portions of the institution. In the third section of the T there will be wards—5 to 8 beds. "We saw as many as 51 patients in a ward in one New York hospital—a deplorable condition. We found patients occupying the bath, and two in some of the beds. We are providing glass screens to make cubicles. Wards are provided for convalescents; and next them are the solariums—solariums in winter and balconies in summer. Each floor will have a 10-foot balcony extending across the end of the ward—40 to 50 feet long. The second floor will be used entirely for pay patients. We have concentrated the utilities as much as possible in the centre of the T. A suite of clean-up rooms will be provided, the last opening into the cor-

ridor or open air. The doors are so arranged that they cannot be opened to pass back into the institution. There is also another central feature—a clean-up for patients as they go out—from the bath room they pass into a clean room, where they get their clothes. It is intended to have two lavatories—one for patients being discharged and one for general use. The diet kitchen opens opposite the lavatory on the open-air corridor through two windows. Through one the food is passed in and through the other the utensils and dishes, after sterilization, are passed out—but these will be as few as possible. In the central part of the T, on each floor, there will be an incinerator—a series—one over the other. This wing will be 13 storeys high and accommodate 300 patients. We will have an alarm on each floor, covered with glass—to be used only in case of emergency, such as a patient strangling. We have provided an opening at the centre of this T—a small visiting room. The patient will be brought out, so that the mother can see her child without coming into contact with it. We will have steam in several rooms of each floor. Our admitting rooms will be as central as possible and very small—easily cleaned and easily fumigated. They will connect directly with a lavatory. Besides the clean-up rooms on each floor intended for doctors' and nurses' use before going to and from their dining rooms, we will have a general clean-up room in the basement, which is well above ground and reasonably light. We have clean-up rooms for doctors, nurses, male help, female help, and patients. Lockers are provided. In the basement we have likewise a large diet kitchen, with all the conveniences of a hotel. Here, too, are the sterilizing room and the laundry in two sections. One clothes chute, which reaches a balcony on each floor, opens outside the building. It also opens on the top. It can be sterilized and washed down. The clothes chute opens into the laundry. One portion of the laundry is for the soiled clothes on first arrival. Between this room and the other is a partition and sterilizing tub—one-half in one portion of the clean room and one-half in the soiled room. This enables infected clothes to be placed in the sterilizer and taken out into the clean room. From here they are sent to the laundry. In the basement will be also rooms for mattresses, for elevator machinery, the morgue, chapel (which can be reached almost

directly from out-of-doors). People going to the chapel are required to pass through the main office first."

Dr. Hornsby followed. Some of us were doing better than those in the rural districts. The medical profession was doing better than the hospitals. Medical men go to the great centres where the material is. They come home with ideas and ideals, and know how to do modern surgery, how to practise modern medicine, but at home they lack hospital facilities and are not satisfied; so they are beginning the attempt to solve the problem. The result will be better hospitals everywhere. In the meantime they are finding little spots in which to do their work in a decent sort of way, in little hospitals of their own. They were taking old dwelling houses and transforming them into hospitals. Dr. Hornsby then threw on the screen several old-style houses, and pointed out how readily they could be turned into small hospitals—provision being made for wards, an operating room, supply rooms, etc. The equipment of these hospitals was not expensive—a water, dressing and instrument sterilizer—$200 to $250. Operating room equipment, $200. A few hundred more would pay for many furnishings. The speaker gave a partial list of the supplies required.

Dr. Herbert C. Cole, of Bogalusa, La., read a paper on the "Possibilities in the Routine Practice of a Small Hospital." As it was impossible for the writer to hear the reader we quote the printed abstract appearing in the announcement:

A small hospital, isolated by hundreds of miles from the great centres, will lend itself to modern up-to-date routine practice under properly applied technique and rigid discipline, if there is the ambition and the administrative faculty in control of the institution's activities. There need not be vast expenditure or elaborate equipment.

Dr. Cleveland Shutt, of St. Louis, condemned the European idea of hospital construction, which meant the spending of as much money as possible and giving service to the least number of patients possible. The spreading out of buildings increases the initial expenditure and does not afford proper facilities for the care of patients. We should aim to provide the greatest possible facilities for the least possible expense. The German ideas and ideas carried out in other countries have been contrary to

that. They seem to be afraid to get up in the air. Dr. Shutt compared the Government hospitals of Germany with the municipal hospitals of America. The systems were quite different. Only a portion of the revenues of American cities went to the building and maintenance of hospitals. The money had to be used to the best advantage; and the multi-storey plan was the most economical to construct, and the cost of upkeep was less than that of the hospital of the low pavilion type.

In St. Louis they were building a contagious hospital on the unit system—a separate unit for each of the more important contagious diseases; and one for miscellaneous diseases, such as whooping cough, chicken pox, erysipelas. Isolate everything and carry out asepsis, just the same as is done in the operating room. They provide a small room in each unit for the nurse, with glass walls, to give her a view of the patient at all times.

The original plan was for an eleven-storey building, but public sentiment was against it. A number of physicians who had travelled in Europe opposed it. They were told it was only a matter of time until they saw storey-hospitals in every city. They were erecting a four-storey hospital of the L type—administration in the angle. The diet kitchen is near the inner angle. They were not providing a building for private patients. That was tried out in Philadelphia, but there was not sufficient patronage to maintain it.

Dr. Joseph B. Howland, discussing Mr. Stevens' paper, opposed the establishment of incinerators in individual ward units. If they came into general use they would be found to be expensive. In the Massachusetts General Hospital all refuse, garbage and dressings were sent to a central room and inspected. The results of such inspection led him to believe that if nurses and help were allowed to burn up the stuff in the ward there would be considerable loss. Inspection of garbage shows whether a nurse is serving too much food and gives a clue to certain things not being eaten well, pointing to trouble in the kitchen. If burnt up, they should miss these two points. They also found many things in the garbage. An examination of the dressings showed all sorts of extravagance—safety pins, rubber tubing and things which could be used again.

Dr. Shutt again discussed the question of mixed infection.

In the isolation building, referred to in his former remarks, there were 16 separate units, allowing them to isolate any disease—indeed, to isolate a whole family with a nurse. In each of the buildings two rooms can be isolated at any time.

Dr. E. E. Munger, of Spencer, La., speaking on Dr. Hornsby's paper on the remodelling of old residences, questioned whether the establishment of so many small hospitals, whether remodelled old houses, or built of new bricks, was not the result of personal and selfish interests, rather than the desire to serve. The establishment of the small hospital often did not favor professional harmony and co-operation. They are the cause of discord, jealousy and conflict among medical gentlemen, and encourage general dissatisfaction among laymen. Doctors not recognized in these private hospitals refer cases elsewhere, to whomsoever they care, with or without division of fees. This occasionally reacts upon the proprietor of the small private hospital, who in turn is forced to the wall, or worse. Many small private hospitals were not needed. This was not to be construed to mean that there were not most capable men who were struggling to maintain hospitals for the benefit of the public; but these same men could render much greater benefit to the public and be more deserving of reward themselves were it possible for them to serve the public through a public hospital. In this connection the speaker had called the attention of the Hospital Section of the Association, at the Atlantic City meeting, to the State of Iowa, where efforts were being made to provide hospitals for the people. The experiment of Washington and Jefferson County had proved satisfactory.

Dr. Robinson, of Michigan, said he spoke for a town of 5,000 with a private hospital. Every physician in town sent patients to it and was personally interested. He was surprised that more had not been said about the location of hospitals. Most of our city hospitals are located on street car lines and with the idea of getting the hospital in a central location. One to ten blocks distant means nothing as compared with the comfort of the patient. We hear frequent complaints from the patients about noise. The hospital should be located in a quiet place. The time was coming when we would see our patients treated in the open air with suitable provision for the necessary

baths and toilets. Each hospital should be so constructed that the patient may be pushed right out of his ward on to a porch. Quiet and open air were essential in all classes of cases. The speaker had obtained the best results in a case of pneumonia complicated with inflammatory rheumatism by treatment in the open air in March. He disagreed with the suggestion that small hospitals did not tend towards good work. In his experience they did, and, instead of driving the doctors apart, they brought them together. A small hospital in a town was good for the town, benefiting the patient, the physician and the public. If a physician has the right purpose behind him the hospital is not going to separate him from his confreres. If a hospital does separate physicians in a town, it is because they are not made of the right kind of material.

Dr. John N. E. Brown said he opposed the idea of the multi-storeyed building centrally located, amid the clang, fumes and dust of the city. Where did those of us who were well choose to live when well? In the suburbs or country, if possible. How much more necessary for the sick. Reference had been made to the expense of German construction. He had not the figures at hand, but believed that the initial cost per bed for construction in Germany was not greater than that in America, nor was the cost of maintenance higher. How much pleasanter for patients to be cared for in low-storeyed, homelike pavilions with parks and gardens and fresh air, sunlight and quiet, rather than in a skyscraper, in the hot, smoky and noisy city!

Dr. H. H. Howard, the President, said that if a hospital trustee board built a skyscraper they must remember that another one may be built right across the street and thus shut out light and air from the hospital. Where such a hospital was built, the lower storeys might be used for the officers, the business part and for the employees, and the upper storeys for the patients. It does not do to build patients' rooms where they cannot get sun in the future—especially the contagious wards. We must rely on the sunlight. They had thought of this in the Presbyterian Hospital, New York City. Dr. Howard then had the picture of his hospital plan again thrown on the screen and explained somewhat in detail the arrangements. One of the main aims was to get the patients out of doors, so the modified ter-

raced wards were adopted. Utility rooms are across a hall from the wards, for quietude.

Architect Schmidt pointed out that the cost of high buildings increases with their height, necessitating heavier columns and walls in the lower storeys. Two or three-storey masonry buildings with walls supporting the floors can be built for 25 cents per cubic foot. When you go up 16 to 20 storeys you double that. Mr. Schmidt had noticed, too, something peculiar in the ventilation of high buildings—unaccountable drafts. He had noticed in his own office, on the eleventh floor of a high building, that when the building was closed, as on a holiday, he would feel the air coming from somewhere—rush around through the corridors—these currents would even blow papers off the table. Upon investigation he found that the air came in on the first floor and through shafts reached the eleventh storey, and left by way of a window somewhere. This led him to believe that in very high buildings there would be a circulation of air from one room to another in a way it should not circulate. If high buildings became cheaper the higher one built, as was alleged, they might reach somewhere in the blue sky where they would be found to be very cheap.

Mr. Lamoreaux, in replying, stated that his remarks had resulted in the way he wished—in setting architects thinking. But he questioned the economy of building in the way they had at Johns Hopkins, where in one-third of the building there were no patients. The cost of a small addition to the column was a small consideration as compared with building such extensive basements as was done in the spread-out plan. The speaker said he was building 13 storeys high for 23 cents per cubic foot; this would compare very favorably with most of the two-storey buildings.

This finished the first session, at the end of which Dr. Baldwin, Dr. Collins and Dr. Aucker extended invitations to the Section to visit their hospitals.

The Following is a Synopsis of the Papers Read at the Meeting

As the function of the hospital is being better understood by the laity, it is growing in popular grace. The terror once attendant upon the thought of being compelled to go to an institution as a patient has largely given way to a sense of gratification for the beneficent presence of the "houses of refuge for them that are ill." The medical profession is of necessity giving the hospital, its needs and requirements, the very best of its thought. Medical men are specializing in the work of hospital superintendents, and a physician possessing natural executive ability and good judgment is finding an excellent opportunity for his services.

In discussing the qualifications of a superintendent, H. B. Howard, of Boston (*J. A. M. A.*), notices the more or less prevalent notion that executive ability rather than medical knowledge and skill are requisite. He does not think that medical education is wasted, and points out many ways in which it is useful and even indispensable to the executive head of a hospital, who must also deputize a large part at least of the actual medical treatment to his subordinates. He recognizes the fact that the medical superintendents of insane hospitals are commonly supposed to be at the head of the medical work and to be expert alienists as well as at the head of the business management, and he says it is rather amusing to see the assurance with which some men try to convince you they occupy such a position.

We who know the facts, he says, recognize the impossibility, and he believes the time will come when the superintendent of the insane hospital will not actually claim that he is the leading psychiatrist in his institution. General hospitals, on the other hand, have followed the opposite course. They are quite different from what they were a few years ago, and their management will tax the energy and ability of the best-trained man. In the first place the hospital should be a first-class hygienic machine and the superintendent should be a first-class sanitarian. Physi-

cians are sometimes poor business men, but they must necessarily know more than a layman can of the needs of a hospital. If the staff is to give its best efforts to the treatment of patients it should be relieved from the business details, but it should not have to be overridden in medical matters by a lay superintendent. Medical knowledge is essential in keeping the hygiene of the hospital up to the mark. Every hospital is supposed to exist for its patients, and a superintendent who knows most about the medical and surgical work has the clearest view of the needs of the institution and the highest incentive therefore to look out for its efficiency as well as its economy. Hence the necessity of a medical man as superintendent in a general hospital.

Considerable space was devoted to the subject of hospitals in the Association *Journal* of November 9.

W. B. Russ, of San Antonio, Texas, says that with the advances in medicine there has come a time in which all actually sick persons must be taken to the hospital if they are to receive the care and treatment that the science of medicine is now able to provide. With the perfection of construction and equipment of hospitals there has come into existence a new profession which we have come to call hospital administration, and he reviews the steps which led to this. The hospital administrator must be versed in the principles of the science of medicine "in order that he may co-ordinate the activities of hospital and its varied facilities with the scientific work of the physicians in charge of the patient." There are not many, he says, of the fully equipped and practically trained men for this position, but their number is growing and the demand for their services is great. If the section on hospitals of the American Medical Association is to achieve anything, he says, its greatest field of usefulness will be in the forwarding of the true relations between the medical practitioner and the hospital administration.

P. E. Truesdale, of Fall River, Mass., noticing the large increase in the number of hospitals in this country, says that it is evident that the home can no longer compete with the hospital in the care of the sick. While the prejudice against hospital treatment still exists to some extent on account of the great mortality of cases in these institutions prior to the aseptic era, it is

certainly diminishing. The modern hospital now serves to safeguard the household not only from loss of life and spread of disease, but from the financial stress involved in the proper care of the sick. Taking as an instance a case of typhoid fever, he says that without the hospital an attack of ordinary severity would cost the workingman not less than $200. Added to this are the difficulties of efficient nursing and the necessary precautions against extension of the disease to other members of the family. Many other diseases also might be mentioned that are communicable and preventable. The home environment is rarely conducive to perfect quietude.

While the hospital affords freedom from home and business cares and anxieties, a well-equipped hospital also furnishes the means for laboratory investigation and refinements in diagnosis and treatment, whereas in the home no more investigation is resorted to than is absolutely necessary. The home will answer as a place for the preparation of simple cases and those requiring only internal treatment, but for others the hospital is best. There is also a growing demand for private hospitals, and nearly all general hospitals have found it necessary to add private pavilions to their general plan. This is another fair index to the change of attitude toward hospitals on the part of the public. While there are some model private hospitals, investigations show that the majority are modified apartment houses operated for profit and lacking the true advantages of a hospital. Some have risen and flourished that in some respects have not compared favorably as regards safety with the home. Truesdale advocates the licensing of all hospitals with a standard that will make them in truth safer than the home for the care of the sick.

W. H. Welch, of Baltimore, believes that from the point of view of the various fields of hospital activity hospital work may be classified as humanitarian, scientific and educational. The care of the sick and injured is primarily humanitarian, but it is not always easy to convince trustees that the others are also essential functions. Welch points out that the furtherance of scientific medicine is also essential to the public welfare. Medicine of to-day is very different from that of former years—it has become more specialized, and the hospital will have to become the laboratory of the clinician. And by such use, scientifically directed, is

the possibility of solution of the great questions in medicine that are constantly appearing. The use of the hospital for educational purposes is, he says, the great problem of to-day. The theoretical subjects are outstripping the practical ones, and the important thing is to bring the clinical subjects up to their level in medical instruction. The most urgent need is to secure teaching hospitals, and it can only be met through hospitals belonging to the universities. It is for the interest of the patient and the public that such relations should exist.

E. E. Munger, of Spencer, Iowa, advocates the establishment of rural hospitals, holding that the rural population has not the same opportunity for health conservation as have urban residents. While the mortality rate for most diseases is lower in rural districts than in cities, it is possible that cases requiring hospital treatment are sent to the cities and in case of death are reported there. One notable exception is typhoid, the mortality from which is higher than in the cities, and in case of perforation the country physician's patient has scarcely any chance of life. Munger gives statistics of other diseases, such as appendicitis, showing how much less a chance of life the country patient has in this disorder, as well as in some of the complications of maternity. He refers to the recent legislation in Iowa enabling the establishment of country hospitals, not to supplant the standard hospitals, but to give every citizen a chance. He believes there should be developed a public hospital system, fashioned somewhat after the public school system, and that our national health should be looked after by a special department of the government.

F. A. Washburn and L. H. Burlingham, of Boston, discuss the problem of hospital organization, leaving out of consideration the open hospital in which any reputable physician can treat his patients, assuming that no one would claim that such an organization makes for the best care of patients or progress in medicine. The usual type of staff organization is the rotary one, the members of each service taking one shorter or longer term of duty each year. This interests a larger proportion of the profession in the hospital and gives opportunities to a larger number to become proficient. Against these advantages it may be said that the short term of service does not favor continued

studies of cases or research, and while many may become proficient, few excel. It does not improve the teaching function of the hospital, and appointments on such a staff may be political and otherwise not of the best. Other types of staff organization are that with continuous service, and the mixed type, rotary and continuous.

In the continuous type the heads of departments are supposed to be chosen on account of merit and not necessarily from the local profession. This type of organization favors and gives opportunity for research, and patients are under careful and continuous observation. Teaching can perhaps be better carried on and it is argued that it is financially more economical. On the other hand, it does not distribute its benefits as widely in the profession or arouse the same interest in the public, and the scientific attitude of the men in charge does not necessarily insure the best care or greatest happiness of the patients. The authors' search through the literature revealed only two articles in which the rotary system was defended, and none in which the utilization of the hospital for teaching was considered other than beneficial to the hospitals themselves. Two suggestions are mentioned as of interest. One was to eliminate any routine succession in the hospital staff and the other to have a continuous service of five years as juniors and five years as seniors and then retirement from active service.

The plan followed in the Massachusetts General Hospital, an attempt at combining the advantages of both rotary and continuous types of staff organization, is described in detail. The relation of the hospital to the medical school is discussed. The benefits should be mutual, the hospital profiting from having men of eminence on its visiting staff and from the stimulus afforded for careful study, and the medical school, of course, from the clinical facilities afforded. The authors think that the hospital should have something to say in making staff appointments, and that it might also well bear some of the expense involved in availing it for medical study. As regards training schools for nurses, they believe small and special hospitals cannot expect to attract the best candidates for such work or furnish the necessary material for their education. They should

not attempt it, but should go to the expense of employing graduate nurses.

In the discussion of civil hospitals one should also consider the military and naval hospitals, which include some of the best institutions in this country. In the above symposium Colonel Charles Richard, of the medical corps of the army, describes the organization, duties and achievements of the army medical corps in times of peace and also that of the organized militia. He points out the inadequacy of the present personnel to meet the complex questions of sanitation, etc., and says that we are justified in the belief that this inadequacy can be best relieved by drawing on the civil hospitals for the medical staff trained in hospital methods. Especially will they be invaluable to the military service in case of war in the general and base hospitals. It was with this object in view that the law establishing the medical reserve corps was enacted. This corps is composed of active and inactive members; the former are assigned to duty with troops and supplement the regular corps; at present there are approximately 125 of these officers in active service. The inactive list of this corps numbers over 900, including former volunteer and contract surgeons of the army and many eminent hospital physicians. In case of emergency when called into active service they would be assigned to the particular duty for which their experience and special qualifications best fit them. Richard believes that the civil hospitals can give valuable aid to the country by stimulating interest in the army as a career for well-trained and capable graduates. The same class of men is also desirable for the medical reserve corps, and we must appeal to the generosity and patriotism of such should the emergency arise calling them to active service. Their training should not be postponed until the emergency comes; they should be afforded the opportunity of gaining the practical experience with troops essential to their efficiency as military medical officers. Here again much can be accomplished by the civil hospitals through concerted action on the part of their staff, looking to the enactment of the legislation necessary to make such opportunity possible. The naval hospitals of the service are minutely described in a comprehensive article in the United States Naval *Medical Bulletin* for November.

The most successful hospitals to-day, says J. B. Murphy, of Chicago, are those that are in sympathy with their staff. The essential for the best results is the rendering to the patient the highest type of scientific service, and for this it is most important to find out about him—to obtain a history—before one makes a move, and this is the hardest thing to obtain. The clinical history is more important in many cases than the physical examination or the laboratory findings—and yet who obtains this history? Often the most incompetent man, the newest interne. It should be the senior one; there has been a greater percentage of wrong diagnosis from imperfect case histories than from anything else. A longer term of interneship than the present one is also a necessity. We must follow the German custom and the one who is to become junior or senior assistant in the departments of medicine and surgery should remain three or four years to round out his apprenticeship. There will be a radical change in hospitals in the near future; the general cleanliness and asepsis of the whole hospital as well as the operating room must be looked after. The next thing will be the administration of the therapy, sero-therapy and vaccine treatment, and the best trained men from that point of view will be required. Murphy mentions the failure of his inquiries regarding hospital asepsis as a matter to receive the attention of the Section on Hospitals of the American Medical Association. He also recommends the dividing of the section into committees of investigation of hospitals, the work being definitely mapped out and conscientiously performed. It is the sacred obligation on the part of the section to see that all the work within the hospital is conducted to the very best advantage of the patients admitted.

The following is the hospital organization suggested by H. M. Hurd, of Baltimore: There should be five principal divisions: medicine, surgery, obstetrics, psychiatry and pediatry. The medical department should have the care of diseases of the head, chest and abdomen; of the stomach, bladder, the blood and blood-making organs; and systemic diseases, such as rheumatism, gout, rheumatoid arthritis, parasitic diseases, kidney diseases, intestinal diseases and nervous diseases. To the surgical department he assigns general surgery and the specialties of brain surgery, surgery of the nose and throat, chest surgery, orthopedic and

genito-urinary surgery, and gynecology. The obstetric department should comprise the lying-in cases and care of infants and nurslings. The psychiatric department should comprise all mental diseases. The pediatric department should care for all diseases of children—scarlet fever, diphtheria, measles, chicken-pox, etc. Many of these specialties are so important and cover so much useful treatment for teaching that subdivision may be advisable.

In discussing the out-patient work of the hospital, R. C. Cabot, of Boston, says that it is obviously the duty of the up-to-date dispensary, when one patient with infectious disease applies for treatment, to send for the rest of the family exposed and have them examined. One case of rickets is a symptom of more cases in the family; one case of vulvovaginitis means a nest of them in the neighborhood. Out-patient work naturally leads us to the beginnings of things, and in this it is different from ward work, which deals mostly with isolated cases of developed disease. It is just in the incipient stages that phthisis, stomach trouble, malnutrition, lead-poisoning, etc., can be most successfully treated. The community profits far more by bud-nipping treatment in dispensaries than by the palliation of advanced disease in hospital wards. The dispensary hits the problem in three most vital points, while the hospital cannot. It can root out foci of disease, check it in its incipiency and keep the chronic patients from lapsing into discouragement. In spite of all this, we still allow the tradition of superficial slovenly work in dispensaries to go on. The remedies for this are two, he says: more science and more Christianity. Hurry, crowding and lack of assistance should be done away with, and we need the Christian spirit to make our treatment effective.

M. M. Davis, of Boston, believes that the general conditions of efficiency in out-patient service are these: 1. The skill and interest of physicians. 2. The technical equipment for medical and surgical work. 3. The character of the medical organization, the arrangement of services and the general administrative system as a whole. 4. The extent to which the clinics are provided with an organized, paid service, including nurses, social workers and clerks. 5. The extent to which the social problems of patients are dealt with in a definite way. Each of these con-

ditions must be studied separately and, while much attention has been given to the first two and considerable to the third, the fourth and fifth, and particularly the fifth, have been largely neglected. One of the greatest drawbacks to efficiency of an out-patient department is the failure of the patients to return, and to meet this he has had a "follow-up" department. Almost every case of tuberculosis, syphilis and many other diseases is a social as well as a medical problem, and proper conduct of cases in both these regards costs considerable, but Davis thinks it worth while in spite of expense. He has positive testimony from the physicians where it was tried that it was better for them professionally, and we may be sure that the patients did not get less benefit. He presents these considerations and the tests described as only a beginning experiment and suggestive of still better methods.—*The Medical Times.*

Hospital Intelligence

Strathcona Hospital

By November next, the new hospital at Strathcona will be put in commission.

St. Thomas Smallpox

A new smallpox hospital is to erected at St. Thomas, on the recommendation of the Provincial Health Officer.

Medicine Hat

An Isolation Hospital, on the cottage system, will be built at Medicine Hat. The present hospital is overcrowded.

Arduous Campaign

Henderson, Kentucky, has been campaigning for the proposed new City Hospital, which will be built at an early date.

Quebec City Hospital

A civic hospital is proposed for Quebec City. The site is not yet selected. Mayor Drouin is chairman of a committee to settle the question of site.

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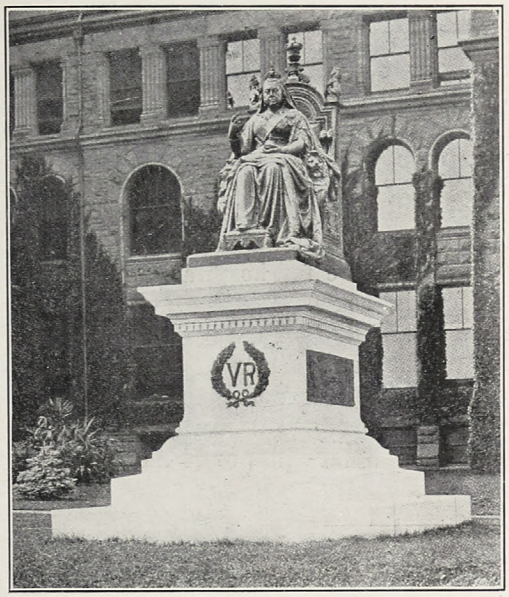
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Onliwon Cabinets

Quite the best device of its kind that has yet appeared is the new "Onliwon" toilet paper cabinet, now being introduced by the E. B. Eddy Co., Limited, of Hull, Quebec.

From the viewpoint of both cleanliness and economy, the "Onliwon" is indeed superior to the ordinary toilet paper holders. There can be no waste and no litter. It is well finished and nickle plate, and makes an ideal fixture for hospitals and other public buildings, as well as for the home.

For a limited period, the E. B. Eddy Company is offering one cabinet, complete with sixteen thousand sheets of Eddy's best quality, chemically-purified toilet paper, express prepaid to any point reached by railway east of Sudbury, Ont., for $2.50. Remittance may be made to the company at Hull, or to any branch or agency.

The Ostermoor Mattress

The hospital superintendent who is re-equipping his institution with bedding should ask for prices from The Alaska Feather and Down Co., of Montreal. This firm make a specialty of hospital bedding, mattresses, pillows, springs, etc. But few superintendents do not know, for instance, of the Ostermoor Mattress, an article to which the Alexandra Hospital, Montreal, for instance, has given the hardest kind of use for six years and still found in good condition. Can anything be said more conclusive, and in these days of hospital expenditure will it not be wise for hospital purchasing agents to bear in mind the word "Ostermoor" when ordering new bedding?

Prophylaxis

Physicians are becoming more and more impressed with the value of prophylactic measures. Therefore, to instruct patients of the gentler sex in hygienic and sanitary principles and procedures is both a duty and a privilege. Ignorance and false modesty frequently hinder or prevent the adoption of means which favor physical well-being and peace of mind.

Cleanliness of the genital tract is for women not only a valuable sanitary and hygienic measure, but also in many instances an absolute necessity, in order to prevent physical irritation or discomforts as well as mental unrest.

The proper use of the Marvel Whirling Spray Syringe is not only instrumental in the treatment of diseased condition, but is also of great value as a prophylactic measure.



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THE CHAIRMAN OF THE HEALTH COMMITTEE of the Chicago Board of Aldermen, the Hon. Willis O. Nances, declared in a public address on June 23:

> "INVESTIGATIONS made by the press and others have shown poisonous drugs are too easily obtained in this city. There is really little excuse for the use of mercury by the public generally. Peroxide of hydrogen or boric acid, neither of which is a dangerous poison, will usually serve the purpose of antiseptics in the household."

TO INSURE ABSOLUTE SAFETY see that you get HYDROX CERTIFIED Peroxide of Hydrogen. The "CERTIFIED" label over the cork attests the purity, high test, and keeping qualities of the contents.

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An Important Digestant

It was but recently when it was supposed that the chewing of food stimulated certain nerves, which stimulated the flow of the peptic juices.

To-day it is known that the internal secretions from the salivary glands, going through the blood, activate the peptic glands and in the same other internal secretions activate the glands lower down in the alimentary tract.

Nineteen years ago, clinical experience led to the statement that Peptenzyme contained some principle which assisted the digestive organs to resume their functions by starting the normal active digestive secretions. To-day we know that Peptenzyme contains these activating enzymes. Thus clinical results antedated the isolation and naming of these enzymes by ten years.

After all, it is the clinical results that physicians want to know.

The question, however, is asked, why is it that Peptenzyme always gives such uniformly good results in all cases of disturbance of the digestive tract, whereas other digestives, such as pepsin, pancreatin, or the vegetable ferments and their combinations, have been used without success? The answer is that many forms of digestive disturbance may be laid to the weakening or absence of the internal secretions, and these cannot be supplied either by pepsin or vegetable ferments. The nucleo-enzymes alone contain these activating zymogens, and Peptenzyme is composed of the nucleo-enzymes of all the glands which go to aid digestion.

From the very beginning, Peptenzyme was recognized as a scientific digestant. The late Dr. Hunter McGuire said, "After using it thoroughly in a dozen cases, I think it is the most important product you have sent out."

After all these years, it still remains the best and most important digestant.

Sanitary Wall and Woodwork

White enamel for interior walls and woodwork of hospitals, sanitariums, public buildings, etc., is conceded to be the most sanitary and suitable coating for the purpose, in that the surface produced by its use is pleasing and durable; while through years of wear very little effort is required to keep it sanitary.

The enamel most widely known and extensively used throughout the world is Satinette, distinguished by the fact that it is easily applied, exceedingly white, and will not turn yellow if applied over a properly prepared surface.

Satinette is made by Pinchin, Johnson & Co., Limited, London, England. It is imported and sold in Canada by the International Varnish Co., Limited, Toronto, who have the exclusive rights and are always pleased to give detailed information pertaining to this immaculate finish.

The New Toronto General Hospital

IS a marvel of completeness to the most minute detail. Nothing has been neglected in the perfecting of the most up-to-date hygienic, sanitary and perfect institution of the kind on the Continent, if not in the world and the Board has the gratitude of the great public at large, not only of Toronto and Canada generally, but of the hospital workers of the entire country, who regard this as a model.

The drinking water supplied to the patients is produced by the TRIPURE Sanitary Water-Still process, in use by the United States Government in their Army and Naval Hospitals and Departments, War Vessels, etc.

This water is distilled and triply purified and oxygenized during vaporization, making it potable, palatable and delicious—really an artificial rain water—and is absolutely pure and sterile—so pronounced by the World's Congress on Hygiene and Demography.

TRIPURE Water will be frozen in Carafes in the most up-to-date manner by a Kent Ice Machine, thence to be delivered at the bedside of individual patients.

The installation of these two standard plants in a building specially built and designed for them demonstrates the infinite attention to detail and convenience of operation and to the comfort of patients which has been lavished upon the work.

The Sanitary Water-Still has been adopted, as it is the only Water-Still which returns to the vapor all the oxygen removed in the boiling, thus doing away with the flat and insipid taste found in all other distilled waters. The cost of operation is practically nil and the space occupied—often a desideratum in compact work—is no more than used by an ordinary kitchen hot water tank, and requires no expert care or attention.

The Sanitary Water-Still Co. of Canada, Limited, is prepared to figure on all hospital work and furnish apparatus producing from 125 gallons per 24 hours up to 10,000 gallons.

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Sanitary Water-Still Company of Canada, Limited

Keith Fans.

Messrs. Sheldons Limited, of Galt, Ont., recently received Keith & Blackman Company, Limited, of London, Eng., the manufacturers of "Keith" fans, now being adopted in many hospitals. He says:

"I have seen your letter of the 1st inst. and note with pleasure that you are doing a good business in the Keith fans, which business will doubtless go on increasing by leaps and bounds, as it is doing on this side and all over. I should imagine, however, that should you either come over here or send over one of your principal experts to go through our shops both in London and Scotland, you will be much better equipped for creating these fans in all their forms more profitably and efficiently on latest up-to-date lines.

"It may interest you to know that lately the Keith fans have been adopted by the Cunard Company. They are now in use in the 'Lusitania,' 'Mauretania,' 'Andania' and 'Alaunia,' these two latter boats being just completing at Greenock for the Canadian trade, and being wholly fitted with Keith fans; all of which business used to be the select preserve of the Sirocco people. So much satisfaction have our fans given to the Cunard service that practically none but the Keith fans or wheels will be used on the greater 'Aguitania,' just launched on the Clyde, while the whole plan of cooling or ventilating of the three great engine rooms on board the 'Aquitania' was designed by ourselves, and Keith fans will wholly be used, the atmosphere of these engine rooms being arranged to be changed to the extent of 120 times an hour to keep it sweet and fresh.

"We have just opened a separate and entirely new fan works in Arbroath, Scotland, principally for the manufacture of mine fans, and which will certainly be the best equipped fan works in these isles. The Keith fans of large size are specially adapted for mine ventilation, have already been a great success in the north of England, and at the present time we have practically all the orders for mine fans in the Newcastle-on-Tyne great mining district; the Capeland and the Sirocco forms being now discarded there in favor of the better Keith form of fan.

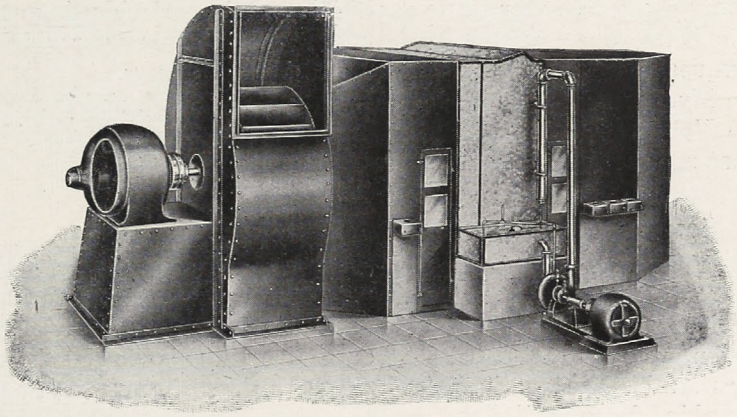
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The Canadian Feather and Mattress Co., Limited, Spruce Street, Toronto, wish to call the attention of hospital superintendents in Canada to their facilities for turning out in any quantity and on the shortest notice their well-known line of bedding. This firm makes a specialty of the highest grade goods only, and, as will be seen from their advertisement on page lv of this issue, they manufacture a full line of hair and felt mattresses, as also hair or feather pillows, comforters, etc. Doctors, ask them for prices.

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Physicians, nurses, and all who are familiar with the innumerable uses of peroxide of hydrogen, will be interested in the fact that a "Certified" label is now placed on the cork of every bottle of Hydrox Certified Peroxide of Hydrogen. The label certifies the purity and keeping qualities of the contents, and is signed by a well-known analytical chemist.

This feature is important because of the frequent complaints of ordinary peroxide of hydrogen deteriorating, losing its potency, and even exploding, after a comparatively short time. The Hydrox Chemical Co. do not wire the corks of their bottles, which shows that there is no expectation of the corks blowing out. The bottles are new and carefully treated. Ordinary peroxide is frequently bottled in unclean second-hand containers.

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A Severe Burn

H. B. Lee, M.D., of Summerville, S.C., writes as follows:

"My first use of Antiphlogistine in burns and scalds was accidental. I was called by telephone to Mr. J. T., aged twenty-seven, weight 180 lbs., brickmaker, a steam-pipe having exploded between his legs, scalding him badly. I ordered that no grease of any kind be used, but that cloths soaked in a strong solution of bicarbonate of soda should be laid on the parts till I could get there. I stopped at a drug store to procure another salve I had used in such cases, and by mistake the clerk gave me two boxes of Antiphlogistine. When I reached my patient I found him suffering intensely with a big blister extending from the crotch to the angle on the inner side of both legs, at least three inches wide and surrounded by a red inflamed surface two inches wide on each side.

"I had used Antiphlogistine before in pneumonia and in sprains, so when I found that by mistake this had been sent I decided to try it. I covered the entire injured parts with a thick layer of Antiphlogistine (applied cold), put absorbent cotton over all, and after bandaging loosely to keep things in place, took Mr. T. home in my buggy. When I first saw him his face was contorted with pain and he could not suppress the groans that the agony wrung from him, but, as I covered more and more of the burnt surface with the dressing, I could see the expression of pain leaving his face. I gave him some medicine to relieve pain and when I called again that evening I found he had not touched the anodyne. I asked him why he had not touched his medicine. 'Well, doctor,' he said, 'you told me to take that every two hours while I was in pain and I have not had any pain.'

"The next day I let him leave his room and in three days he was back at work. I did not touch the dressing for five days, and when I took it off the parts had healed entirely."

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When a material can be secured that embraces both of these features in an unusual degree, and at the same time combines the important advantages of extreme *lightness*, maximum efficiency as a *non-conductor of sound, neater workmanship, rapidity of construction* and *economy*, its consideration is a matter of vital importance to the hospital superintendent.

Keystone Gypsum Blocks offer all of these advantages and many more that cannot be secured by the use of any other fireproofing material. The steadily increasing use of this material during the past fifteen or twenty years, in the largest buildings in the country, is convincing proof of the satisfaction it has afforded. Further testimony is found in the fact that Keystone Blocks are continually specified by those who have once used them. An initial sale may be the result of good salesmanship or low price, but *repeat orders depend solely upon quality*. Nothing could be more suitable for a hospital or any building harboring the sick. Full particulars can be procured through Douglas Milligan, Limited, Confederation Life Building, Toronto.

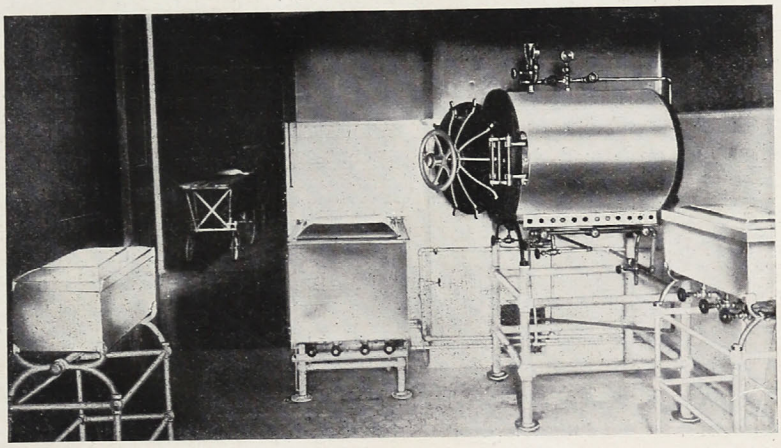
Cooling Hospital Wards in Summer

For some time we have been urging the desirability of providing a means of regulating the temperature of hospital rooms and wards in the summer as well as in the winter, and we would again call upon hospital administrators and architects to attack this neglected problem.

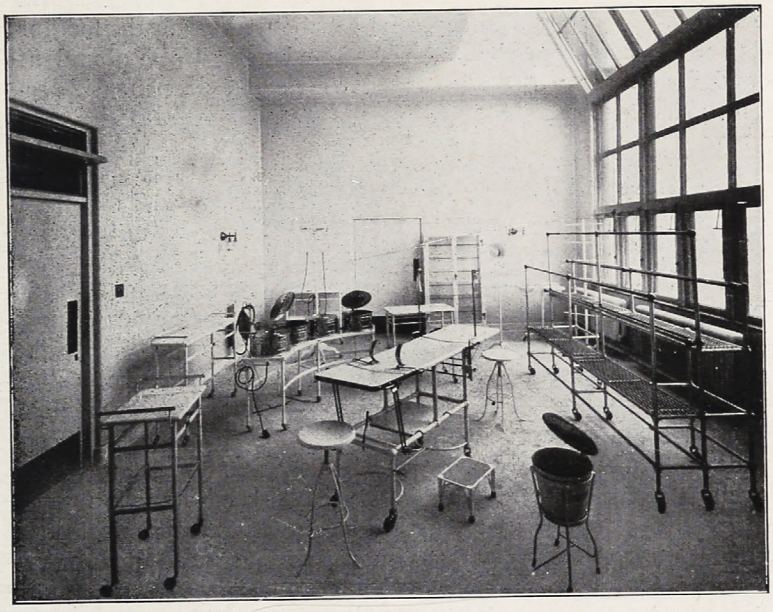
As far as we know, no serious effort has been made to study a means of cooling hospital wards during periods of great heat. Nor do we know of any statistical study concerning mortalities in hospitals during such periods. We cannot rid ourselves of the impression that unusual atmospheric heat does, at least occasionally, tip the scales against very ill patients balancing between life and death. And we need no statistics to satisfy ourselves that, at any rate, heat spells add enormously to the suffering of patients swathed in dressings and struggling against the effects of narcosis and a major operation.

In a small room an electric fan adds enormously to a patient's comfort on a hot day; but what is to be done for the sufferers in large wards? An adequate automatically regulable cold air supply is the most rational system, and it would seem only a matter of mechanical experimentation to evolve it. Air sucked over brine pipes can, by means of a pump or blower, be delivered through ventilators sufficiently cold to cool a large room. The chief cost would be that of installation. The operation in a building supplied with refrigerating pipes would not

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be expensive; nor would it be required except during periods of unaccustomed heat. Moreover, the installation in hospitals already constructed might be provided for only a few wards or large rooms, to which patients most affected by the heat could be moved. For hospitals yet to be built, however, a complete ward cooling system ought to be included in the plans.*

In the absence of some adequate system of cooling by cold air or cold pipes, what can be done during torrid spells to reduce the discomfort of sufferers in hospital wards? In rooms not too large a series of fans, not too near any patient, might be operated at one end; and, indeed, the air might be blown from them over large blocks of ice, as is sometimes done in theatres. If this is not expedient, the sickest patients should be removed to well-shaded small rooms, where they may have the benefit of wall, ceiling or window fans. Water curtains can be operated to reduce room temperatures, but they constitute a crude method. Light, frequently changed bedclothes, cool drinks, frequent sponge baths and protection from flies and mosquitoes are the nursing contributions towards the amelioration of the patients' discomfort. The surgeon can contribute as much—prophylactically—by postponing operations of election during unusual heat spells; actively, by minimizing the bulk of dressings and bandages. Caps, tapes and straps can often be substituted for bulky roller bandages about the head and neck, while abundant wound discharges may be managed with small dressings if frequently changed.

*In Mount Sinai Hospital, New York, such a scheme is being tried, experimentally, in a single room. Whether efforts have been made elsewhere or not we do not know.—*Am. Journal of Surgery.*

Hospital Lockers

The "Meadows" Locker for hospital use has several outstanding features peculiar to itself—of which their patented locking device, "Sure-Grip," is perhaps the most conspicuous. The lockers themselves are made in the most substantial manner, using angle steel framing for the body of the locker, also angle steel frames for the doors. The firm follows the practice of using standard butt hinges securely riveted to the frames with only the barrel of the hinge exposed, realizing that this construction gives the greatest strength at the points where the strength is most needed. There are many patented novelty hinges used for lockers, but none of these give the strength and appearance of the standard butt hinge. Their booklet "Locker Lore" supplies more detailed information regarding lockers, which will be sent to any interested parties on request.

From the wire department of this firm much work has been executed for the Canadian hospitals, such as wire milk bottle baskets, wire balcony guards and wire cages for the insane. Their products of this nature are of such quality as to warrant their installation in Canada's largest hospital—the new General Hospital, Toronto.

The Hospital World

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All Communications, Correspondence and Matter regarding Subscriptions and Advertisements TO BE ADDRESSED TO THE HOSPITAL WORLD, 145 COLLEGE ST., TORONTO, ONT.

Vol. IV TORONTO, OCTOBER, 1913 No. 4

Editorials

A NEW HOSPITAL JOURNAL

The Modern Hospital is a new publication under the management of Dr. Ball, of St. Louis, who made such a success of the *Tri-State Journal*. Dr. John Allan Hornsby, late of the Michael Reese Hospital, Chicago, has been chiefly instrumental in bringing this new periodical into existence: he has applied the *vis a tergo*. The infant is a lusty one; and we wish it and

its sponsors much success. There is plenty of room at the bottom, as well as at the top. There are lots of topics, and numbers of hospital workers to express themselves. *The Modern Hospital* will be a good medium for such expression.

The journal is about the size of the *American Magazine,* is well printed on fine, calendered paper; and it has a fine advertising patronage.

Its editorial staff is made up of Drs. H. M. Hurd, F. A. Washburn, Winford H. Smith, S. S. Goldwater, J. G. Mumford, W. L. Babcock and J. A. Hornsby, so there should not be lacking plenty of sound editorials.

The more the merrier. The WORLD wishes *The Modern Hospital* all success.

MISTAKES IN PLANNING

IN discussing Mr. Keith Young's paper, delivered at the British Hospitals' Association, Sir Henry Burdett advised that, "when constructing or altering a hospital the great need is to have a consultation between the architect and those who would be called upon to work in the hospital. And when once the plan and system has been decided upon no subsequent interference with the plans during erection should be permitted. Such interference invariably adds greatly to the expense."

These are words American hospital authorities may ponder over. In too many instances proposed hospitals, the cost of which runs into hundreds of

thousands or even millions, are placed in the hands of architects of little experience in hospital construction. They collaborate with hospital officials and doctors whose knowledge in this respect is about on a par with that of the architect. The result is the adoption of plans incomplete and faulty. Errors of omission and commission are discovered during the progress of construction, the correction of which must necessitate the expenditure of thousands of dollars.

To proceed with the building in such a case would be much worse than to make the clearly indicated changes for betterment.

Of course, Sir Henry meant that the plans must be as nearly perfect as possible before proceeding with construction.

The British people, we believe, do see to it, to a greater extent than those on this side of the water, that architects and hospital officers have a reasonable knowledge of hospital construction.

In America we have two or three centres in which hospital administration can be studied, and the time has arrived when there should be centres for the teaching of hospital construction.

In nearly any of the score of American cities of over half a million population hospital building is constantly in progress, and there are many new structures which may serve as object lessons for intending architects and administrators.

Until we have such teaching centres it would be advisable that young architects, or administrators who seek to do hospital planning, should spend a year

or more in studying our recent American hospitals as well as those of Great Britain and Germany.

The hospital architect and the hospital administrator should be each the complement of the other in knowledge of hospital construction if they would plan a building so ideal that no change of plan in any detail might be found necessary.

CLINICS FOR FATHERS

First the children, then the mothers, and now the fathers are being brought into line.

The Children's Homeopathic Hospital of Philadelphia is establishing a series of clinics for fathers, to be conducted throughout the winter. The hospital authorities state that it is almost useless to teach the mother how to care for her children if the father refuses to co-operate.

There is no reason why fathers should not be instructed in household hygiene. The mothers' clinics have brought the fact to light that the average working man objects to the disappearance of the roller wash towel, sees no use in going to the expense of fly screens, spits on the floor, and indulges in other little ignorant and careless habits which militate against a sanitary home and frequently stultify the mother's efforts.

All these things are to be talked over in the evening clinics that are to be given by the doctors connected with the hospital. Young unmarried men as

well as fathers will be invited to the clinics, which will include a course in sex hygiene.

This is a move in the right direction. Too much responsibility in these matters has hitherto been thrown on mothers and wives. There is no adequate reason why the fathers and husbands should not be held equally responsible, nor why their education along this line should be neglected. With the aid of lantern slides or moving pictures, clinics for fathers could be made both instructive and entertaining. The movement is full of possibilities.

HELP FOR THE HANDICAPPED

From the founding of the first hospital up to the present those in authority have utilized the service of a certain class of patients, handicapped or convalescent, primarily for the advantage of the hospital, occasionally as a factor in the patients' recovery.

It has been not unusual for patients to volunteer their services for light duties that would make the long hours of slow healing or convalescence pass more quickly. And any hospital worker can testify to the often excellent reactive effect upon the patient of such small voluntary service as his strength has permitted.

It has remained, however, for the hospital social service department in its progressive and varied phases of development to seize upon this capacity and desire for action in the physically disabled, and to utilize it for the patient's material and physical advantage.

Dr. Herbert Hall has done wonderful things at Marblehead, Massachusetts, where he has established a system of handicraft work adaptable to the special need of handicapped patients. Dr. Hall began his work as a philanthropy. It is now a self-sustaining industry. But more than that, it is a magnificent social service that brings to the disabled the dignity and joy of worthy production. Dr. Hall's success has led to the taking up of a similar work in the out-patient department at the Massachusetts General Hospital.

A still later experiment, and one that will be watched closely by hospital workers everywhere, is the recent establishment of the Industrial School for Convalescents at Sharon, Conn. The great purpose of this movement is the amelioration of anxieties suffered by the disabled or slowly convalescent. The foundation of this school is the result of the energy of a number of devoted and enthusiastic men and women connected with three New York hospitals.

The Burke Relief Foundation, which is to establish the greatest convalescent home in the world at White Plains, N.Y., is financing the present undertaking, since the enterprise will afford an interesting study to those in charge of the Burke fund. For in some of its phases the Industrial School will present on a small scale some of the problems that will be met later at White Plains.

The especial object of the school, however, is to provide a home for those convalescing from heart disease, to give the patients an opportunity to learn a

trade, the pursuit of which will give them a livelihood, without imposing too great a strain on the impaired organ.

When it is remembered that some thousands of persons are admitted to the hospitals of New York every year, suffering from some form of heart trouble, and that as soon as they are able to be about the majority of them are obliged to take up work involving strain, with the probability of a relapse, the significance of this experiment becomes apparent.

DR. OSLER CONCERNING HOSPITALS

In opening the recent meeting of the British Hospitals Association, Dr. Osler, presiding officer, gave one of those forceful epigrammatic addresses for which he is noted. The professor talks in terse Anglo-Saxon and flings out crisp statements without hedgings or provisos, but with a humorous, common-sense and sure reach to the heart of things, which makes all he says worth listening to.

In his first sentences he disclaims any technical administrative knowledge. "I have persistently avoided knowing anything about hospital administration as such. If the patients were comfortable, if the beds were clean, if the nurses were happy and the house physicians well housed and fed, I knew that the administration was sound."

That's a good common-sense test, and the one taken by the ordinary lay person. One of Dr. Osler's

strong holds upon the public lies in the fact that he never loses the public point of view.

But his years of close association with American hospitals, and his recent experience of British hospitals, has given him points of comparison evidently in favor of the former.

The four points of his speech were well taken. First he pronounced emphatic condemnation of the British system of voluntary hospitals, by which only the pauper poor are treated in the large public hospitals, while those who can pay have no recourse but to go to private nursing homes, as they are termed.

Secondly, the doctor scores the absence of proper clinical and pathological laboratories. Those that do exist, he declares, are "shockingly behind the times. Upon chemical and bacteriological research modern medicine is built, and you cannot have proper treatment of your patients, you cannot have the cases investigated properly, unless you have a good chemical, a good bacteriological, and a good pathological laboratory in connection with the hospital."

Thirdly, Dr. Osler believes that every hospital should have at least one purely consultant physician in residence. "With the development of modern medicine it takes so much of a man's time for special study and research that it is impossible, if he has to earn his living by taking care of patients in general practice, to keep thoroughly up-to-date in laboratory methods and in methods of research."

And his fourth point concerned the need of utilizing the County (or smaller hospitals) for purposes of

instruction. "This work is of the greatest importance. The county hospital should not only be the consulting centre for the doctors of the neighborhood, but it should be the centre to which they should come for systematic instruction."

Dr. Osler's advice to the British Hospitals Association is equally applicable to the thousands of smaller hospitals in America.

In most of our smaller community hospitals, every doctor practising in the vicinity is on the staff, many, perhaps the majority, doing general practice. If some arrangement could be made by which the work would be divided, one or more taking general surgery, another general medicine, another midwifery and gynecology, another eye, ear, nose and throat, the division being according to local and medical demands, the value of the hospital as a consulting and educational centre would certainly be increased, and post-graduate work could be carried on by these physicians, who would naturally become specialists in their several departments.

Such an arrangement, together with the establishment of the laboratory, which Dr. Osler so strongly urges, would materially raise the standard of the smaller hospital, and give professional stimulus throughout the community in which it is situated.

WHICH WAY?

While we are growing more advanced in our hospital building requirements each year; while the multi-million-dollar hospitals are increasing in

number, and costliness in building is the mode, there comes a suggestion from across the water that may give us pause, and lead us in a new line of thought.

Mr. Conrad W. Thies, Secretary of the British Hospitals Association, who has been visiting this country recently, and incidentally inspecting some of our new and costly hospitals, considers that the modern hospital should not be so solid, elaborate and expensive in construction.

Age decreases the sanitary conditions of a hospital, he says; also the science of hygiene is making such rapid progress, that in less than a century the buildings should be really renewed in order to keep them hygienically up-to-date. If hospitals of to-day were built on a lighter scale, such as that of the Swiss Cottages, so that the buildings can be replaced at a comparatively small cost, Mr. Thies thinks the economic and hygienic values would be enhanced. The gentleman has had both observation as well as practical experience in the difficulties of attempting to modernize some of the century-old English hospitals, in order to bring them up to to-day's scientific requirements. He declares that, solid as they stand, it would cost less and be more satisfactory to pull them down and rebuild.

The point taken by our English visitor is one provocative of discussion.

There is no doubt that more money is being spent on hospital construction with each successive decade. Some of the recently built hospitals have cost $3,000 to $4,000 per bed. When one remembers that this amount is more than many a whole family pays for

its permanent home, this lavish expenditure stands out with peculiar and questioning significance.

This liberal outlay is due to many causes, chiefly, perhaps, because there is greater wealth in the country and our rich men are growing more humanitarian. Also, there is the growth of civic consciousness and civic pride; and pressing up on these motives is the educative force of modern medical science, which is finding out and demanding the best curative conditions for the sick.

The question is in how far would it be possible to simplify hospital construction without sacrificing the patients' welfare. Could the more expensive kinds of stone or brick be replaced by cheaper grades of the same material? For instance, in two recently constructed city hospitals the face brick in one has cost seventy dollars per thousand, that in the other fourteen dollars per thousand.

Would a flat roof of concrete or of tar and gravel prove as satisfactory and durable as one of costly slate or tile; terrazzo as serviceable as a floor of tile or parquetry, and methods of natural ventilation supplant the installation of expensive and involved artificial systems?

Could the costly operating rooms with their elaborate suites and expensive finish be reproduced in simpler material than marble and tile?

Might not the same principle be observed throughout the building, not in construction alone, but in matters of equipment, where the most costly is not necessarily the most serviceable or sanitary?

Could the apparent excessive cost of construction be in some such manner materially reduced without in any measure sacrificing the efficiency of the hospital; and does the suggestion of Mr. Thies strike a new note in hospital construction?

CONFERENCE NOTES

THE American Hospital Association is to be congratulated, at the close of this its fifteenth conference, upon the large measure of success that has attended its efforts in the years since its inception. It occupies a field of effort distinctive, and of great educative value in the economic world.

That it is an acknowledged authority and influence in the hospital field is due to the unremitting efforts of a score of hospital superintendents—busy and much taxed men and women who have freely given time and labor to this purpose. Each annual conference finds the organization more permanent, more necessary and wide-reaching. It may be safely predicted that the association will continue to grow in power and educative influence, provided the sound judgment and wide-visioned purpose that has actuated its membership in the past be continued.

In the onward movement of all benevolent organizations there are tendencies to be avoided if the highest point of efficiency is to be reached.

One of these is the tendency toward autocracy in government. The few members whose untiring

efforts and enthusiasm have built up so efficient an organization continue, naturally, very much to the front, while the larger and later body of members remains inactive.

The strength of any organization is to be reckoned only by its working capacity; and the measure of its success is in proportion to its ability to utilize the full resource of its entire membership.

Each organization may plan new and constantly varying methods of accomplishing this.

Officers should go around among the members. In event of the organization being a national one, the ex-officers would make an experienced and valuable consulting board. The executive might be composed of one member, at least, from each State or Province, the said member to be elected by those of the association who come from the State he represents. Such a committee would be invaluable because of its detailed knowledge of the hospital strength in both men and institutions of each State.

Every effort should be made to prevent a national organization from coming under the control of any local coterie, no matter how excellent its purpose may be. Breadth of vision, good judgment, large and kindly tolerance, enthusiasm and unremitting effort to bring out all the latent ability of its membership—this will spell continued success for any organization.

A minor criticism, overheard at the Association, was made by a member who, perhaps, travelled further than any other, in order to attend the meeting.

The papers read were too long, he asserted, and the time allowed for discussion too short. The second came from a Chicago member who commented in adverse terms upon the lack of entertainment offered to the Association as a body.

The first criticism was perhaps not without justification, and will doubtless be considered next year. Concerning the second, the Association some years ago decided that no social function should be included in the yearly programme of the conference. It appears a wise provision and one that it is hoped will be maintained. Social activities in connection with conferences of all sorts have been altogether overdone during the past few years. They have become a burden to both the entertainers and the entertained. The annual meetings of the American Hospital Association are conducted with a greater sense of freedom and independence, and a better concentration upon the work in hand, without them.

The papers read were very good, and covered a variety of topics. The President's address was a valuable one. Dr. Fowler's happy resolution was unanimously adopted; and from now on we hope to see many heads of training schools and members of hospital medical staffs present at the meetings.

Contributions such as that given by Miss Parsons, of the Massachusetts General Hospital, will always be welcomed. Those by Drs. Edsall and Lea, of the same institution, cannot fail to be helpful to the association, given as they were, from varied viewpoints, of

questions in which all these co-workers are interested. Dr. J. M. Peters' report on Hospital Construction, while touching on features of several large new hospitals now building, gave special space to the new Peter Bent Brigham Hospital.

One day of three sessions was given over to the consideration of questions affecting smaller hospitals. Very active discussions took place. Special mention should be made of that which arose out of the reading of Mr. G. W. Olson's paper on Methods for Increasing the Receipts of Smaller Hospitals. The practical nature of this paper shows that the Association is fortunate in the accession to its ranks of the author.

Next year the members of this section would welcome two days of papers and discussions concerning smaller hospitals.

The committee on arrangements must be complimented on the ability with which they performed their task. The accommodation at the Copley-Plaza was excellent. A suggestion might be made that the commercial exhibit should in future be placed near the convention hall. This feature of the Association which has been carried on successfully for two years should receive encouragement, and its committee should have the co-operation of every member.

Original Contributions

PRESIDENT'S ADDRESS, FIFTEENTH ANNUAL CONFERENCE, THE AMERICAN HOSPITAL ASSOCIATION

FREDERIC A. WASHBURN, M.D.,
Administrator, Massachusetts General Hospital.

THE President of this Association finds one of his most difficult duties is the preparation of the annual address. My first task when this duty became urgent was to read the messages of my predecessors in office. These addresses have been strong as a rule; they have placed the ideals of hospital administration upon a high plane; they have been worthy of the men who have written them. The topics discussed have been many. Among these I find certain definite recommendations which, as no action has been taken upon them, it is well to again emphasize.

In 1908 Dr. Goldwater was impressed with the fact that the Association was becoming too large and its personnel was too complex to work to the greatest advantage in a single section. This is more true to-day than it was then. At the present Conference your President and Executive Committee are attempting in a small way to try the experiment of section work. I will ask you to watch and see whether it is a success, and, if it is, to take action so that your next President and Executive Committee may have the authority of the Association for repeating this step and perhaps adding other sections.

Dr. Goldwater also recommended the addition to our membership of hospital physicians, surgeons, pathologists, and superintendents of nurses. By the timely suggestion of Mr. Ludlum, our President in 1906, the Association was broadened from a society of hospital superintendents to the American Hospital Association. Can we ever be all that name implies until we admit members of our staff and superintendents of nurses? The hospital problems of the future and of the immediate present cannot be handled by hospital administrators alone; we need the help and close co-operation of our staffs of physicians. As

that is the case, they can best discuss these problems with us at our conferences as associate members of this body.

If superintendents of nurses were associate members, I believe that we should have a better understanding of each other's aims and purposes, and that harmony in the hospital world would be promoted. A training school section may very well be one important part of our annual conference.

Let me make a strong plea for such a change in our constitution as will again broaden our membership and make us truly the American Hospital Association.

In 1910, Dr. Howard, then your President, made a most important recommendation: He called attention to the fact that hospitals can best be placed upon a high plane and kept there if some system of inspection is adopted. We all need and would profit by friendly criticism by competent authority. Dr. Howard thought that this could best be done by the individual States. He was influenced in this belief by the successful work in this line done in insane hospitals by the Massachusetts State Board of Insanity. The objection to doing this work by States is that the effect of comparison is lost. We would wish to compare one large general hospital with another doing substantially the same work, to compare the standards of a hospital in the East with one in the West. During this meeting a definite plan for such inspections will be proposed and the Association will be asked to express its approval or disapproval. To me this scheme of inspection, if it can be worked out under auspices in which we have confidence, promises a most important step in advance. From the statistics gathered we should eventually learn the essentials of a model hospital of each class. Hospitals would soon learn that a low per capita cost is not the first requisite; that high-grade modern work needs first-rate personnel in all departments; complete system of records; all modern contrivances for scientific research; and a spirit of investigation and teaching. How better can this be brought out than by comparison of hospitals trying to do a similar grade of work? It is, of course, essential that this should be done by a person with the requisite hospital knowledge, and in a spirit of the utmost fairness. Hospital trustees would welcome friendly criticism and suggestion and the information that their institu-

tion is not in all particulars the acme of perfection would do them no harm. When this plan is proposed, I bespeak for it your careful and best thought and favorable consideration.

I now come to the subject upon which I wish to lay special stress in this my Presidential message to you.

GOOD ORGANIZATION THE PRIME REQUISITE FOR MEDICAL AND SURGICAL EFFICIENCY.

We have to thank Johns Hopkins for the introduction into this country of paid chiefs of medical and surgical services with continuous duty.

The great professional departments of a large modern hospital should each have a single head with a service uninterrupted except for the necessary vacation. This makes possible an effective planning of the work. These heads of departments, or, when the departments are too numerous, representatives of them, to make a committee of not more than five or six, meet with the superintendent of the hospital and consider the problems of medical and surgical administration and the great questions of the medical and surgical policy of the institution. The superintendent should be required by the rules of the trustees to be present at their meetings also. Here we have an efficient organization. The superintendent is able to get the advice of the ablest men on the staff in the many problems where he needs such advice. He is the agent of this small representative body of the staff, of which he is a member, in carrying out their orders where they properly have jurisdiction. By his presence at trustees' meetings he is able to clear up many points which are not entirely clear to his Board and to turn their thoughts toward the problems which need their consideration.

Here is an organization which will give us efficiency to meet the great questions which are pressing upon us. Preventive medicine: how can the hospital best help? How co-operate in the prevention of occupational diseases? Social service: how far are we warranted in going? What shall be our attitude towards workmen's compensation and other forms of insurance which affect hospitals? Hospitals are in a particularly advantageous position to help eliminate social disease. Clear-headed judgment is required in this. How shall we steer our course so

as to best protect the community at the same time that we guard the rights of the individual and retain his confidence? These are a few of the questions.

We hospital superintendents need all the aid we can get. The staff is a better staff if a small representative committee knows and discusses these hospital problems and advises and acts upon those subjects over which it properly has authority.

In some hospitals there exists jealousy of the staff by the superintendent, and jealousy of the superintendent by the staff. There will be no better way of doing away with this than by creating an organization which will make trustees, staff and administration pull together for the good of the whole institution. The chief of a medical or surgical service can no longer give what the modern hospital requires by visiting his patients for an hour or two daily. The hospital should demand that each chief shall devote at least a half of each day to its service; that private practise shall be secondary. In this way only can we get the highest efficiency. The ideal chief of service should have youth, yet his judgment must be mature. He must have vigor and enthusiasm. He must be just and generous in recognizing and promoting the efforts of his subordinates. He should be able to plan pieces of investigation for his staff and stimulate their accomplishment. He should see to it that the expensive "hospital days" are not wasted either by patients waiting the convenience of the surgeon for operation or by unnecessary stay in the hospital from sepsis.

How can we obtain such services of such men? Only by paying them adequate salaries. The standard of efficiency of an entirely unpaid medical staff has in many instances been high; but it does not meet the requirements of the present day.

You will perhaps ask me what concern this is of the hospital administrator who is not charged with the treatment of patients. My reply is that the modern medical administrator of a hospital is not doing his duty by the community or by his trustees by simply attending to the housekeeping or by limiting his duties and responsibilities as they have often been limited in the past. By acting with a small medical board, he should see to it that nominations to the trustees of the men to fill vacancies on the staff are the very best possible, and that when these men are

appointed they work for the greatest efficiency of the hospital and not for their personal aggrandizement. The superintendent of the modern hospital, to have the highest efficiency, must keep in touch in a general way with the problems and progress of medicine. The Medical Board may make efficiency tests of the work of the various departments, or it may delegate this work to a committee reporting to them. Just as it is well for a hospital to submit to inspection and criticism, so it is of advantage to have the different departments examined. In this way we may stimulate careful productive work and prevent slipshod work.

This committee may, for instance, take the records of a number of cases of a certain sort in one out-patient department and examine them to see if the patients received a thorough examination; if all the laboratory tests were made; how many visits there were; the results of treatment and whether advantage was taken of all the facilities for treatment furnished by the hospital. No harm is done if this committee interests itself in some of the functions of administration. It may well watch the admission of patients in the out-patient department; see if there is unnecessary delay; if applicants are handled with kindness and good judgment. If these duties are not well performed, no one is more desirous of knowing it than the superintendent. It hurts none of us to be checked up and be given friendly criticism.

Let us then impress upon our trustees the necessity of paying adequate salaries to these chiefs of service; for we cannot demand from them the work we need until we are prepared to pay for their time. This does not at all mean that we are to throw away the voluntary work of men who make their living by practising medicine and surgery. Their services are of the greatest value to the hospital, and the hospital work is of the greatest value to them. The community needs that they should have the experience which only the hospital can give. Inasmuch as the hospital is necessarily secondary to their private practice, they must be content to work under the leadership of those who are paid to make the hospital work their first interest.

My message to the larger hospitals is, then: Give more attention to medical and surgical efficiency, and to that end get the

right men for chiefs of service and pay them adequately to devote a large measure of time to the hospital.

A word about the small general hospitals: I recognize that much admirable work is done in these institutions. I believe, however, that sometimes too little thought is given to the community need when such a hospital is started. Often a hospital could be erected at a central point which would serve several towns and be able to command better work than could several smaller institutions in the various towns. There is a tendency in some of the smaller hospitals for members of the staff to attempt surgery for which they have had no adequate training. In some places this has been a crying scandal. Medical associations are now proposing to license surgeons. This will help a great deal, but there must be developed a public sentiment which will make ignorant surgery impossible. A surgeon of small experience must learn that it is no disgrace to admit that a given patient's chances are better in the hands of another man and transfer the invalid to the metropolitan hospital, if feasible.

Well-authenticated report comes to me that in some hospitals in certain sections of the country the standards of deportment, decorum, and, in some instances, even decency, are low. The relations of staff and nurses are altogether too intimate. No hospital with low standards in this particular can ever permanently flourish or do good work. I wonder if this has anything to do with the difficulty of some of these hospitals in getting nurses. To any of you who know that I am justified in making these charges I leave the answer to this question.

Too many small hospitals are started without adequate provision for their support. The result is a constant struggle and a probable attempt to make the unfortunate nurse in charge carry a greater burden than anyone should be asked to carry, both in hours of work and responsibility.

We should all use our influence against the starting of a hospital until it has been clearly shown that it is necessary; that the location suggested best meets the need; that there is adequate support in evidence, and that its conduct is in the hands of those whose ideals are high and whose methods are practical.

In 1905, when this Association last met in Boston, I well remember hearing an honored superintendent of long experience

urge that meetings should be held once in three years, because all the subjects of interest to hospital superintendents had been pretty thoroughly discussed. This was just before any adequate realization of the expanding work of the modern hospital and the responsibilities of its administrator. In selecting topics for my words to you, I have been embarrassed not by the paucity of interesting subjects, but by their multiplicity.

I thank you for the honor which you have conferred upon me in making me your President, and it is my most sincere wish that this meeting may be productive of benefit to the hospital world.

NATIONAL INSURANCE IN GERMANY AND ENGLAND*

BY DONALD J. MACKINTOSH, M.V.O., M.B., LL.D., F.R.S.E., OF GLASGOW, SCOTLAND.

NATIONAL INSURANCE IN GERMANY.

I HAD the great privilege some four years ago of attending the conference of the American Hospital Association which was held in Toronto, and you then did me the honor of appointing me an honorary member, a distinction which I prize very highly, as there are, so far as I know, only two honorary members from Europe on that list.

When your worthy president asked me to come over to Boston and read a paper this year bearing on the National Insurance Act in Germany and England, I felt I was bound to respond either by coming and taking part in your deliberations or sending a paper on the subject he mentioned.

I regret my inability to be with you, but I will endeavor in the paper which I am forwarding to deal with the subject in a clear and direct manner, and probably the better way to approach the subject will be to give you a brief history of medical benefit in Germany, as it provides an interesting introduction to the same subject in England.

In Germany the control of medical benefit is in the hands of the societies, and there are no intermediate bodies. Conditions of service and matters relating to control are arranged directly between the medical practitioners and the society.

It often happens that the doctors in a district are combined together in a federation, and the societies will combine together in a similar federation; terms will then be arranged between the two associations. It is obligatory on the societies to provide medical benefit. If they do not, appeal can be made to a supervisory authority which intervenes and makes arrangements with the medical practitioners, which are binding upon the society. In certain exceptional cases, where it is impossible to arrange

*A paper read at the conference held in Boston, Mass., on August 28th, 1913.

medical treatment, money benefit, not exceeding two-thirds of the ordinary benefit, may be given.

There has been a bitter controversy between the medical profession and the societies for years, and it has received a stimulus recently from the increase in the wage limit from £100 to £125 per annum. The full aim of the medical profession has been to have unrestricted free choice. Against this the ideal of the society has been to have no choice, but that in each district the insured persons must go to one doctor. It is not perhaps too much to say that unrestricted free choice of doctor has its disadvantages in the excessive strain it places upon the funds of the society. Similarly where an insured person has no choice the outlook for the medical profession is bad, especially for the younger members who are just entering upon their professional duties. In certain places an agreement has been arrived at between the two systems by allowing free choice from a number of doctors appointed by the society. Freedom of choice has been an important factor in forcing up the remuneration of the medical profession, because there are invariably more doctors than are required, with the result that all endeavor to obtain payment of a sum which will give them a living remuneration. Under a monopoly of service a few people draw large sums and farm out to younger practitioners. A large number of societies have conceded free choice among an association of doctors where such a body has been organized. An important group of societies is that federated under the title of the Leipzig Sickness Funds. This Society makes agreements with the medical practitioners, who have formed two official associations which include all the practising doctors within their areas. Any doctor belonging to either of those associations can make a contract with the society to give medical attendance, and the members of the society have a freedom of choice from doctors who have entered into these contracts. This arrangement very largely approaches to the system in England, with certain differences which will be manifested later when the English system is described.

Disputes between the doctors and the society have to be determined by the Arbitration Committee. The appointment of this Committee, which acts as a conciliation committee, was the

result of a long and bitter controversy. The Society had for a long time given choice to their members of a large number of doctors, having in 1904 agreements with 233 doctors to provide medical treatment at 4s 6d. per member per annum, for which sum dependents of members also had to be treated. Naturally the doctors demanded higher rates of pay; the rates they asked for were 4s. per member without dependents and 12s. per member with dependents. In reply the Society offered a capitation payment of 5s 6d. per member. An additional demand on the part of the doctors was that in the future payment of medical service should be arranged between the Society and the Medical Association, and that agreements with individual doctors should not be terminated at the will of the society. Negotiations did not produce any result, and on 1st April, 1904, the doctors declined to come to terms. The Society adopted the only measures which were open to them, as practically all the doctors in Leipzig and neighborhood supported the profession, by importing doctors from other centres. These methods were not successful. On petition being made to the supervisory authority to compel the Society to provide the medical benefit which was obligatory under the law, that body decided that 112 doctors were necessary to give efficient medical service, and, as the Society was unable to obtain this number, the supervisory authority entered into contract with the organized doctors under the following terms:

1. There should be free choice of doctor.
2. 5s. per member without dependents, 3s. per person entitled to benefit with dependents, and 3s. per dependent.

A counter-balancing provision was made that if the total expenditure of the Society on money benefit and medical and surgical appliances exceeded a certain sum the excess was to be deducted from the sums available for the medical service.

The agreements entered into with the doctors who had been imported were to remain firm, but were to be terminated at the earliest possible moment. An important feature of the agreement was the provision for the establishment of committees for controlling the doctors and for settling disputes. The Society as a last resort removed medical treatment to dependents from

the list of benefits, thereby reducing the amount payable in capitation fees to the doctors.

Matters continued hostile for some time between the organized doctors and the imported doctors. Ultimately, in May, 1905, the Society and the organized doctors came to terms, and agreed to those fixed by the supervisory authority, except that where there were dependents entitled to medical treatment the capitation fee should be somewhat lower. This agreement in 1910 was renewed for six years, providing for an increase in remuneration.

A conflict also occurred at Cologne, where the sickness societies had employed district medical officers, leaving their members no choice, but gradually free choice among a small number of doctors had been conceded. At first the doctors appeared to be in the ascendant, as the supervisory authority fixed the terms of an agreement over the heads of the Societies. The Societies, however, were able to satisfy the requirements of the supervisory authority by showing that they had a sufficient number of doctors to give service.

The reason which prompted that step was the enormous increase to an average society in the cost of various services. For instance, a medical service which in 1903 cost 2s. 11d., in 1906 cost 5s. 2d., and in 1908, 8s. 3d. Similarly money benefit had increased from 11s. per member in 1903 to 14s. 9d. in 1908. In 1909 fresh arrangements were made, and there has been a considerable drop subsequently in the expenditure to the society. The doctors have gained something in the struggle with the extension of the principle of free choice of doctor and also an increase of remuneration, although a considerable portion goes to the imported doctors. But the enormous increase in the expenses of which I have just given an illustration, where the doctors were more or less uncontrolled, has also had its effect upon public opinion. There must be such a thing as free choice, and the medical profession can always demand with proper organization a fair remuneration and probably be successful, but if they are reckless in giving certificates for incapacity for work, and in their demands for remuneration, the effect must be to bankrupt the society which is the source of the remuneration.

I have gone into this matter at some length because the question of control in England depends upon the way the medical

practitioners act. At present there is an agitation, which may increase unless doctors are more careful with medical certificates, for the appointment of State medical referees, but it has not reached important dimensions. There is also an agitation by friendly societies that the control of medical benefit should be placed in their hands. I do not suppose that if a service is given by the English medical practitioners which does not imperil the stability of the societies that the question will arise.

Various other methods are adopted in Germany as to the control of the medical service. The members of the Leipzig Sickness Society have free choice of doctor, and the doctors are controlled through an association of their own. Any complaints are made by the society to the association and the latter investigate the matter. The society has power to fine a doctor for giving an improper certificate, etc.

At Munich there is a somewhat similar arrangement, but separate committees of doctors control charges, prescriptions and certifying of patients as incapacitated from work. Many of the societies have doctors acting as confidential advisers, who examine patients suspected of malingering, and who are consulted when there is a doubt whether an insured person should be sent to a hospital or not, as in Germany the society has to pay a *certain sum when their members are treated in hospitals.* The societies consider the use of these officials justified because where there is free choice of doctor there will be considerable variation among the medical practitioners as to what constitutes total incapacity. They also perform a useful service, because where a doctor is in doubt on a particular case he can always refer the matter to the confidential adviser.

The following particulars for 1910 of the work of the two confidential advisers of the Leipzig District Society make very interesting reading, and it will be seen that the confidential advisers send a large number of persons off the funds of the Society.

LEIPZIG DISTRICT SICKNESS SOCIETY.

8,497 requests were made for visits to patients to ascertain whether they were genuinely unable to work.
3,382 of the requests were made by treating doctors.

2,494 of the requests were made by the head office of the society.
2,399 of the requests were made by the supervisors.
222 of the requests were made by the visitors.

Of the 8,497 patients—
111 were excused.
1,259 did not come for examination.
1,300 notified recovery before examination.

As regards the 5,827 examinations made—
47 per cent. of the patients were declared able to work forthwith.
12 per cent. of the patients were declared able to work at the end of the week.
10 per cent. of the patients were to be re-examined at the end of one or two weeks.
31 per cent. of the patients were declared unable to work.

4,218 cases were reported for visiting to decide whether the patients should be sent to a cure establishment or a convalescent home, or for a stay in the country.
582 patients did not appear for examination.
3,636 patients were examined.

625 cases were reported for examination as to whether special medical or surgical requirements should be given.
108 patients did not appear for examination.
517 patients were examined.

1,735 persons were examined who applied for voluntary membership of the society.

Complementary to control is the arrangement between societies and doctors for discussing matters of policy. The Leipzig has an excellent system of a conciliation committee which consists of three representatives of the doctors. That committee discusses matters of common interest and settles disputes. There is also an arbitration committee which consists of three representatives of the society and three doctors and in addition three Local Government officials. One of these officials is the chairman, and the committee acts as a final court of appeal for settling disputes. There are conciliation committees on similar lines,

with slight variations as to appointment of chairman, existing in various parts of the Kingdom.

As to remuneration of the medical profession in Germany, most of the large societies pay a capitation fee of so much per member. In some places, such as Leipzig, the whole of the money available for medical service is handed over to the medical associations, and they in turn distribute it among their members in proportion to the amount that would have been received had an insured person been attended as a private patient. The tariff is drawn up as to the charges for various services performed by the doctor, and the doctor receives either payment of his account in full, or if the amount of money available is not sufficient then he receives a *pro rata* amount.

Arrangements on similar lines are made at Munich and Frankfurt-on-Maine, but in the last-named the doctor is not allowed to commence his services until six months have elapsed since he made his application, and during the first three months he has to attend various meetings, generally to make himself familiar with his work.

Where the members have not free choice of doctor and whole time service prevails, there the doctor is remunerated by a fixed salary or on some percentage basis.

The Kiel District Society gives some figures as to the income received by the 34 doctors having agreements with that Society. One doctor received over £600, two doctors received between £500 and £550, two between £300 and £400, nine between £200 and £300, eight betwen £100 and £200, and twelve under £100: the average works out at a remuneration of £200 per annum.

The following facts as to capitation fee per member paid to medical practitioners by the Leipzig District Society are interesting:

3/- to the end of 1887, attendance on dependents included.
3/3½ from 1st Jan,, 1888, attendance on dependents included.
3/7¼ from 1st Oct., 1888, attendance on dependents included.
3/10¾ from 1st July, 1896, attendance on dependents included.
4/2½ from 1st Oct., 1897, attendance on dependents included.
4/6 from 1st Oct., 1898, attendance on dependents included.

5/- from 7th May, 1904, without attendance on dependents.
6/6 from 1st May, 1905, attendance on dependents included.
7/3 from 1st Jan., 1911, attendance on dependents included.
7/6 from 1st Jan., 1914, attendance on dependents included.
For a member without dependents the capitation fee is still 5s.
The present agreement is in force until 1916.

The payment by the same society for various treatments in the year 1910 were as follows:

Total amount paid		£74,531
This amount included—		
Capitation payments	£56,101	
Special fees to the society doctors	3,660	
Payments to practising doctors employed at salaries (under old contracts)	551	
Payments to society doctors outside the district	4,215	
Payments to doctors other than society doctors	1,719	
Payments to polyclinics	1,329	
Payments to dental surgeons	4,861	
Payments for massage treatment	396	
Payments to the Zander Institute (for Roentgen Ray treatment, etc.)	314	
Payments to doctors in respect of other expenses	212	
Repaid to members in respect of payments made by them for medical treatment	410	
Payments to the confidential medical advisers	763	

The following table for the year 1910 shows the extent which the treatments of the dependents affects the work of medical practitioners:

Free medical treatment was given to

Members.... 76,572 cases of members who were unable to follow their employment.

212,877 cases of members who were able to follow their employment.

140,021 male members.

72,856 female members.

Total.....289,449

Dependents of members, 248,760

79,235 wives.

161,948 children.

7,577 other dependents.

It will not be surprising therefore that there have been strenuous demands for an increase of rates. This, as I mentioned at the beginning, has been partly affected by the large increase of newly qualified doctors. In 1885 there was one doctor to 3,000 persons, whereas now there is one doctor to 2,000 persons.

Drugs are not dispensed by the doctor, but by pharmacists, who in Germany have a virtual monopoly, as it is difficult to obtain a license by the public authority to trade. Prices, however, are officially fixed, so they cannot charge any prices they desire, but the official tariffs leave them a liberal margin. They have, however, only a monopoly of the sale of certain medical and surgical appliances, and, in the various articles to which their monopoly does not extend, there is keen competition by druggists. As a rule the pharmacists allow members of societies certain discounts from about 10 to 25 per cent. Under the new law of 1909 it is provided that a discount must be given to sickness societies and the authorities are to decide the amount of discount. The prescriptions by the doctors and also the charges of the pharmacists are carefully checked by the societies, and in some cases the societies combine to check the number of certificates given by a doctor to see whether he is too free in certifying inability to work. The expenditure on medical and surgical requirements is very large and averages about 4/- or 5/- a year, but this includes such things as special baths, etc. The societies state that the extension of freedom of choice of doctor is one of

the causes of the increase of expenditure on drugs. One other point has been commented upon by a German doctor who has had considerable experience in insurance work, that where an ordinary person is content to be told that he can be cured without recourse to drugs, the insured person is not content unless he is given a bottle of medicine. It has been mentioned in England that the Insurance Act would have a great effect of reducing the sales of patent medicines. This may prove to be so, but 25 years' experience has not shown it to be the case in Germany.

The following details of expenditure of medical and surgical appliances in the Leipzig District Society and, secondly, in the Munich District Society, are interesting:

LEIPZIG DISTRICT SOCIETY.

£31,483 was expended on ordinary medical requirements, including wine and dressings.
£8,512 was expended in addition on special requirements.

The items included in this £8,512 were:

£4,389	for baths.
1,274	for spectacles, etc.
1,246	for trusses, etc.
621	in contributions towards cost of artificial teeth.
477	for milk.
341	for electrical treatment.
146	repaid to members.
14	for artificial eyes.
4	for ice.

The drugs, etc., were ordered in 773,333 prescriptions, each prescription representing, on the average, a cost of 1s. 0¼d.

MUNICH DISTRICT SOCIETY.

£20,017		was paid to the Munich Association of Pharmacists.
1		" to various Munich pharmacists.
218		" to pharmacists outside Munich.
	£20,236	
£1,150		" for trusses, flat-foot appliances, etc.
768		" for spectacles, etc.

£ 23		was paid	for artificial eyes.
1,501		"	for baths.
523		"	in contribution towards cost of artificial teeth.
	£3,965		
£280		"	to various clinics, etc., in payment for dressings.
150		"	for the checking of prescriptions by doctors.
218		"	for the checking of prescriptions by pharmacists.
	368		
5		"	in respect of the confidential advisers' department.
1		"	in respect of the department of the society for medical requirements.
	£24,855	Total.	

The figures of the total average expenditure for the Cologne District Society for various employees are also interesting as showing the average expenditure per member on medical and surgical requirements and sickness benefits, because it shows the increase that the societies contend is brought about by free choice of doctor. The figures from 1903-08, when the relations between the doctors and the societies were strained, are very instructive.

1903	27s. 6d.
1906	32s. 9d.
1908	37s. 0d.
1910	33s. 3d.

(*To be continued in our next issue.*)

A BEAUTIFUL LIFE AND SOME OF HER MINISTRIES

BY ALEX. GILRAY, D.D., TORONTO.

AFTER the passing of her brother, John Shields, and her sister, Jane, Agnes lived one of the quietest and most retired lives; yet how full of beneficent and far-reaching deeds was that life. True, to only a few intimate friends was the nobleness and brightness of her life known. What a delightful memory it will ever remain to those who enjoyed that rare friendship.

John Shields was a man of large business capacity, and he employed his mental powers to great advantage and thus left his "dear sisters" (as he was wont to call them) a large estate, unencumbered and with no restrictions, only his sisters knew that their brother's wish was that, when they required to draw no more from the estate, it should minister to the poor and suffering. In harmony with this wish and in conference with their physician and friend, Dr. N. A. Powell, they definitely devoted the main portion of the goodly estate for the erection and equipment of an emergency hospital, which now forms an important part of the New General Hospital on College Street and University Avenue.

Not long after the passing of the brother the sister Jane followed, thus leaving Agnes alone. Submissively and bravely she accepted her lot of loneliness. The main thought of her heart was, all through the years that remained to her, how she could most faithfully carry out the parting desire of brother and sister to help the afflicted and poor, and no one more loyally and lovingly fulfilled a sacred trust than did Miss Agnes Shields.

Some of the outstanding features of her character:

First. Miss Shields was remarkable for her profound regard for justice. She had early learned the significance of the Prophet's words, "To do justly." Her first thought ever was, "Is it right?"

Second. Benevolence occupied a large place in the life and deeds of Miss Shields. Only the just can be truly benevolent. During the many years the writer knew Miss Shields he had frequent opportunities of witnessing her ministries to cases of need and affliction. Her own great bereavements and sorrows marvelously developed and sweetened this strongest womanly

nature we have known. Once, after a long and serious sickness, she asked for the points most needing help in the Northwest. To each of these she gave liberally. This was her way of giving thanks. And in the heathen lands there is reason to believe that hearts are rejoicing in the light which can never be quenched because of the benefactions of this womanly woman.

Third. Any description of this character would be seriously inadequate which did not make mention of the fine, rich humor which, like threads of gold, ran through it all. Truly it was no gloomy life which was lived in the apparently secluded home on College and Major Streets. There were times of joy there; clouds were scattered, burdens were removed and borne far away, by a happy and irresistible wit, and all so timely. Lighter hearts more frequently left her tranquil dwelling than entered it. "The joy of the Lord" was verily her strength. This genuine humor rayed forth even in her closing hour, cheering friend and nurse who waited by her bedside.

Fourth. If Miss Shields had a keen sense of humor, a profound regard for the spirit of justice, she also in a beautiful manner exemplified the meaning of the words, "Walk humbly with thy God." In the midst of her noblest deeds to needy causes she manifested the simplicity of a little child. She ever gave, remembering that her Heavenly Father had first given her all she possessed.

It was a happy day to her when it was thought wise to build the Emergency Hospital sooner than was at first stipulated. With singular joy she responded to the suggestion, for she saw the advantages that would follow such change. It was therefore a real satisfaction to her that she was spared to see the walls completed within which so many should be helped and healed.

For the Chairman of the Building Committee of the New General Hospital Miss Shields ever cherished highest respect and esteem, rejoicing that she had the honor of sharing in so great an enterprise. How fitting that such a life should close just after she had repeated the words,

"All my trust on Thee is stayed,
All my help from Thee I bring."

May her example, so lowly and so generous, be a strong call to many of her sisters to "go and do likewise."

"The actions of the just smell sweet, and blossom in the dust."

Proceedings of Societies

THE AMERICAN HOSPITAL ASSOCIATION

FOLLOWING the partial report of the Boston meeting of the American Hospital Association, given in our September issue, herewith we present a summary of other papers presented.

Dr. Michael M. Davis, Director of the Boston Dispensary, presented the report on out-patient work. In six years, he said, the number of dispensaries had increased almost four-fold. The number of patients had not increased in a corresponding manner, as many of the newer institutions were small in size. The increase in patients is over 50 per cent. During the present year there were some 3,000,000 out-patients treated in the United States. Dispensary problems were a part of the public health movement. It was noteworthy how little attention hospitals paid to out-patient departments. Three-quarters of the annual reports of hospitals make no mention of their out-door departments. Others barely mention the matter. Only 8 out of 56 had any special report on the department. Their work ought to be reported.

Dr. Davis had secured information from 49 out-patient departments, and from 27 dispensaries not connected with hospitals. Thirty-one of the 49 had no executive officer in charge; and only 9 of the 27 dispensaries have a permanent superintendent. Six of the 49 pay their medical staff. Nearly one-half of the 49 do not believe in paying the medical men. Fifty-nine per cent. have social service departments. Only 60 per cent kept a list of the names and addresses of their patients; 40 per cent. admit that they do not make routine laboratory tests. Four-fifths of 36 institutions reporting excluded less than 2 per cent of applicants because they were unworthy. Little or no attempt has been made to cost accounting. Some simple method should be adopted. Dr. Davis holds that dispensaries of any size should have a permanent superintendent. They should have a continuous and closely organized medical service. Social service must be developed. The needs of the worthy patients must be discovered. Small fees should be charged. Efficiency tests should

be made, based on the number of visits per patient; the analysis of medical results on consecutive cases, and visitation to the homes of the treated.

Dispensaries should be licensed and regulated. There should be co-operation among the various out-patient departments and dispensaries of a city. Methods of service are not sufficiently worked out and standardized to expect that municipalities will take them over. What is needed is a carefully worked out, concrete statement of at least the minimum requisite for efficient service. The American Hospital Association might work out such a standard. Money was needed, but before adequate support could be expected two things were required—facts and a programme.

NURSE TRAINING.

"For many years the medical profession as represented by State and national medical societies has tried annually and strenuously to raise the bars higher and higher to keep out of the medical profession applicants who have not enjoyed the advantages of a liberal preliminary education," declared Dr. C. A. Drew of the Worcester City Hospital.

Dr. Drew's address was not a part of the set programme. His plea was for a higher standard, and he explained:

"For a comparatively few years the nursing profession as represented by State organizations of nurses has tried to bar out of the profession of nursing those who have not had at least a preliminary high school education. In the one profession an academic college degree has been the standard hoped for. The other profession has hoped for a standard not lower than that represented by a high school diploma. The object of the advocates of higher standards in both professions has been the public good and the exaltation of the profession. While it is granted that a college degree is no guarantee that the man has clean hands and a pure heart, it is admitted that the holder of such a degree has at least been associated with and presumably influenced by scholarly and altruistic men. So it is held regarding a high school diploma, which does not guarantee that a girl is sympathetic or tactful, or even honest. It is against the evidence to assume that there are enough high school graduates to supply

the demand of the fast-multiplying hospitals, and the fast-growing demand for nurses in social service schools and other kindred lines of work. To use a much-worked quotation, 'it is a condition, not a theory' that we are up against. In spite of the many hospitals, Mr. Bradley told us in his excellent paper of Tuesday that 86 per cent. of the sickness in America is in the home, and the evidence seems to prove that the homes of the self-respecting middle class are woefully short of nurses. We need many broadly educated nurses for teachers in our hospitals, for leaders in social service, and for private nursing in many cultured homes; but I suspect we are laying too much stress on education as obtained in the schools and attaching too little importance to constitutional and temperamental fitness, and that education that is obtained in the school of adversity and necessity for self-support.

"My plan would be to judge each case on its merits. Secure a personal interview with the candidate, if possible. If the superintendent of nurses is in doubt, the superintendent of the hospital should also see the candidate; then submit the application in the candidate's own handwriting to the trustees, with such recommendations and evidence of education and fitness as the candidate may be able to furnish. To my mind the time to weed out the unfit is during the probationary period. A good instructor of probationers and a competent and fair-minded superintendent of nurses should be able to decide during a six months' trial whether the girl is possible."

During the morning Dr. William O. Mann, Superintendent of the Massachusetts Homeopathic Hospital, submitted a report of the committees on hospital finances and cost accounting, wherein he disapproved of a complicated system of bookeeping, preferring one that could easily be balanced each month. Others who discussed the report were Dr. John M. Peters, of Providence; Dr. J. R. Coddington, of Philadelphia, and Dr. Drew. Dr. Charles H. Young was to have made an address on "The Private Patient's Relation to the General Service," but lack of time prevented him from preparing it. The programme called for an afternoon session, but as all the business was despatched in the morning, the Association adjourned at 1 o'clock.

Miss Helen Glenn, head worker, Social Service Department, University of Pennsylvania, read a paper on "Some Developments Among Social Lines in the Wards of a General Hospital."

The Social Service Department supplements the work of the other departments of the hospital. In the Pennsylvania University Hospital, workers are assigned to special groups of cases, whether in the ward or dispensary. In 1910, a child was admitted to the hospital with chronic intestinal indigestion, on four occasions, spending 64 days in the hospital. Home care was lacking. The child died. Since social work has been undertaken a child with raditis and indigestion spent ten days in the ward. After his discharge the social worker paid six visits to the home, and the mother came frequently for advice. Patient recovered, gaining 10 lbs. The first child cost the hospital $140.80; the second, $25, including $3 for a social worker.

The social work for crippled children, both teaching and follow-up work, will be done by one person.

The needs of 25 women in a medical ward were: 14 required convalescent care; 11 were worried over home conditions; and 10 were so ignorant of hygiene and correct diet that, without instruction, they would likely have relapsed.

Social service, if needed, should be prescribed by the doctors as a part of the treatment.

Advantage should be taken of the waiting period by pregnant women; they should be taught the care of the baby. Mothers should be regularly instructed along this line.

"The Place of a Social Service Department in a Medical Institution" was the subject of a paper read by Dr. Andrew R. Warner, of Cleveland, before the last night's session of the American Hospital Association at the Copley-Plaza. He said that the work now called social service work in a medical institution is as old as the medical charities. "It is the new way of working, and the larger field that is new," he said.

"Hospitals without a committee of women to visit the sick and to care for the wants, not medical, have been very few in large cities, but a few women could not meet the needs found. Organized hospital social service with a trained staff of workers began in Boston about ten years ago.

Miss Elizabeth V. H. Richards, of the Boston Dispensary, described what social service could do for a dispensary or out-patient department. Miss Helen Glenn, of Philadelphia, spoke on "Social Service Work in a General Hospital." She told of her experiences as head social worker in the University of Pennsylvania Hospital, and described a number of cases in which social service had helped the patients in the wards of her hospital.

Dr. Roger Lee, of Boston, spoke on "What Social Service Can Do for the Clinical Physician." He said that the present advanced stage of specialism and the dropping out of the old family physician created the need for social workers in hospitals. He said that it should be a separate department, and with the wide field for this work it should be a great help to doctors in ascertaining the past lives of patients and their habits and ancestry. He also said that the idea that a patient should be needy before being helped by social service was proved false, that a patient might be very rich but still need it.

At the afternoon session these officers were elected: President Dr. Thomas Howell, of New York; vice-presidents, Mr. H. E. Webster, of Montreal, Miss Mary A. Baker, of Jacksonville, Fla., and Miss Mary Rogers, of St. Louis; secretary, Dr. H. A. Boyce, of Kingston, Ont.; treasurer, Mr. Asa Bacon, of Chicago.

Mr. E. P. Haworth, Superintendent of the Willows Maternity Sanitarium, Kansas City, read a paper on "What the American Hospital Association Can Do for the Hospitals of America." To most of the members the American Hospital Association was a four days' conference. Should there not be a permanent paid secretary, with headquarters? To get the money needed, the membership fee might be increased; or the fee might be lowered and the membership increased. The essayist would not advocate either of these plans. The membership ought to be increased. The essayist would admit superintendents of nurses. The meetings ought to be made as valuable as possible to the members. All hospitals would benefit from coming in touch with the Association. Conditions in some sections were appalling. The Association might publish its own journal, as the American Medical Association does. It might be made a source of income. This journal would educate the public. The secretaryship might be endowed. An expert subscription superintendent might be

engaged. He might be available in cases where hospitals needed to raise funds. Subsidiary associations might be formed. These would reach hospitals which our present Association cannot now reach. These sub-organizations should originate from the American Hospital Association. With its larger vision, it could decide better what States should be included, and could see that no State was left out. The elevation of the standard of the smaller hospitals was very desirable.

Mr. Haworth also recommended the establishment of an institute for the edification and training of hospital superintendents. It might be held annually and embrace the Chautauqua idea. He would suggest it be held on one of the lakes in Indiana, Michigan, or Wisconsin. It had been suggested that this institute might be held in the same city as the annual conference, and at the same time of year. Lectures would be delivered by hospital specialists.

Mr. Olson, of Minneapolis, had written the essayist, recommending that the Association devise a uniform system of cost accounting. The Association should work for the standardization of staple medical and surgical supplies used by hospitals, as has been done in New York City. The Association should formulate a code of ethics to be observed by hospitals in relation to physicians, nurses, and to one another. Co-operation should be had with the American Medical Association and the national organization of professional nurses. The Association, according to Mr. Olson, should include hospitals as members, not the individual persons, and the fees should be graded according to bed capacity. Any trustee or officer should be eligible to participate in the meetings.

Mr. John Wells, of Salt Lake, had also made some suggestions to the essayist. Mr. Wells would like to see the conference held in sections—smaller hospitals' and private hospitals. Too much discussion was given to problems concerning the municipal hospitals and the heavily endowed hospitals, and not enough to those which have to scratch for a living. The commercial exhibit ought to be encouraged.

Mr. Haworth recommends that the non-commercial exhibit should be increased. It was a most important feature of the Association. Many correspondents say the smaller hospitals

should come in for consideration. Perhaps two days would not be too much for them.

Miss Mary M. Riddle, Superintendent of the Newton Hospital, read a paper on the "Grading of Nurses." "If it can be proved," the essayist said, "that more good than harm is likely to result from the proposed grading of nurses, it will be our duty, as it certainly is our pleasure, to assist in its consummation." Leading up to this conclusion, Miss Riddle commenced by quoting from the report of a Chicago meeting of philanthropists, held in 1893, at which it was decided that small hospitals are "in no position to offer adequate teaching experience to a woman who would become a thorough nurse." Florence Nightingale, the highest authority, had emphasized the importance of: (1) Employing methods by which every sick chance will have the best chance of recovery; (2) teaching nurses how God makes health, and how He makes disease, how to handle agencies within our control which restore health and life. This was the present-day principle and tone—better trained people and better service to all classes. The call for the grading of nurses had its origin in the desire of physicians and nurses to secure better nursing for people of moderate means. Previous efforts have been futile because they have been made with the idea of securing the best service without rendering an equivalent, or they have been attempts to adapt the best service to the possible equivalent by an adjustment of the time given; or the patient has been compelled to accept the service for which he could render an equivalent, without regard to his needs. Such failures prove that people of moderate means are satisfied with nothing short of the best.

In 1892 the training of attendants was begun in Massachusetts—for the care of chronic invalids, feeble and elderly people. But these attendants soon laid aside their title and became full-fledged nurses. Their training has been discontinued. Miss Diana Kimber, in 1895, proposed a system of visiting nursing for people of moderate means. But it was found that a very sick patient required so much of the nurse's time that she could not visit a sufficient number of patients to earn a living wage. The plan was impracticable. The Red Cross Rural Nursing Service will assist in the solution of the problem. The Household

Nursing Association of Boston was doing good work along this line. Its interests and purposes were the best, and the work was to be done on a business basis. So with the work of the Civic Association of one of Boston's suburbs—"Community Nursing and Mutual Aid Association." This latter association, instead of grading the nurse, will practically grade the work and furnish a nurse or attendant to fit it. The promoters of this scheme think that greater good may result than from the establishment of a hospital. They are not making the mistake of instituting a hospital and demanding new and unethical systems to maintain it, assuming that since they are filling a need, they are justified in securing the nursing service without compensation of any kind, assuming that for the nurse to require such compensation either in money or opportunity for making herself proficient is treason, because it creates a hardship for the hospital, and possibly for its sick.

Since human nature does not change upon demand, fixed economic laws cannot be broken without destruction of more than themselves, we must doubt the efficacy of the proposed scheme for the grading of nurses, "though," (Miss Riddle says) "we stand ready to extend it a cordial welcome. But would the people in the long run be helped by a system which might eventually diminish the number of good nurses? Is not a chain as strong as its weakest link? Who could tell that a patient may not need the best care? The great middle class is what the world must depend upon, therefore the world should see to it that they have the best. If nurses were properly equipped, and commercial institutions would have better reasons for their existing training schools, but would they make their prices to people of moderate means accord with the service rendered? Doubtless some would. But there is no evident reason why the nurse should be sacrificed, or even exploited, in the procedure. The status of the nurse's calling is precarious, and we cannot afford to make it more so by adopting any scheme which will make the good, intelligent, refined, young woman turn from us, as she surely will if we lower our standards. An honest, sincere young woman, without breeding, intelligence, initiative or wisdom, cannot be so trained that she shall be as useful as if she possessed these qualities—or some of them. We must have the

good woman, above all. The critics work a hardship in two ways—they blame the schools for turning out poor nurses, and make it difficult for the self-same schools to obtain good women. Too few graduates are willing to care for the sick in their own homes. So is it well to encourage this growing tendency? Graduates are being enticed into other fields in the public service. We must keep up our standards to keep our places full of good women.

The so-called overtrained nurse is the product of good practical experience, with too little ethical instruction. She is known for her energy, general intelligence, practical knowledge and courage in undertaking the hardest of nurses' tasks, but fails, or does not come up to the full measure of success.

If nurses could be made to make their application for hospitals through an authoritative body like the American Hospital Association, or if the kinds of training schools could be widely published, as regular or irregular, the results would be less grievous.

Improperly trained nurses should not be sent out into the world armed with a certificate of proficiency to deal with questions of health and disease, life and death..

The essayist holds that grading of nurses is impractical because they cannot be kept graded. It would be dangerous to inaugurate because it would encourage the short-course training school in the purely commercial hospital, thus lowering standards and exploiting nurses, and reducing the number of good women willing to take up the work. In lieu of this, attendants should be trained, but they should be taught and encouraged; but unless she takes a thorough, systematic training, she should not be granted a certificate.

Commercial Exhibit, American Hospital Association.

Among the exhibitors at the meeting were: American Laundry Machinery Co., laundry machinery; Barnstead Water Still Co., water stills and sterilizers; Boston Consolidate Gas Co., gas appliances; Davis & Geck, Inc., ligatures and sutures exclusively; Henrici Laundry Machinery Co., washing machines; Holtzer-Cabot Electric Co., hospital signal systems; H. W. Johns-Man-

ville Co., operating room lighting; Kny-Scheerer Co., hospital furniture, sterilizers, operating tables, general hospital supplies; E. F. Mahady Co., instruments, sterile sutures, medical books, hospital furniture and supplies; Miller Rubber Co., rubber goods manufacturers; Randall-Faichney Co., clinical thermometers, hypodermic syringes and needles; Richardson, Wright & Co., steel hospital furniture and bedsteads, mattresses and pillows; P. L. Rider, crude rubber exhibit, operating table pads, non-rolling pillows, seepage apparatus; Sampson-Soch Co., certified sterile suture material; Sharp & Smith, instruments and advanced hospital supplies; F. H. Thomas Co., hospital furniture, sterilizers, operating tables, general supplies and catgut ligatures, and the Victor Electric Co., X-ray and electric apparatus.

THE CANADIAN HOSPITAL ASSOCIATION

As our readers are aware, the next meeting of the Canadian Hospital Association takes place in Toronto on October 28th, 29th and 30th. Amongst those who have promised to read papers are Mr. Kavanagh, of New York; Dr. J. N. E. Brown, of Detroit General Hospital; Dr. J. A. Hornsby, of Chicago; Dr. Wayne Smith, of St. Louis, and a number of others.

The Executive are very anxious that the 1913 meeting of our Association be the most successful in its history, and all those interested in hospital affairs in Canada are urged to set aside the above dates and come to Toronto and take part in the programme.

The Canadian Hospital Association is a young and rapidly growing society, and can be made of the greatest benefit to hospital superintendents, superintendents of nurses, as well as hospital trustees, if each and all will personally participate in the programme and discussions.

Full particulars can be received from Dr. W. J. Dobbie, Physician in Chief, Toronto Free Hospital for Consumptives, Weston, Ont.

Selected Articles

ALUMINUM KITCHEN APPLIANCES

The increasing use of aluminum for kitchen purposes brings to mind, says *American Medicine*, the controversy that a little while ago raged around the use of enameled ware, particularly of the "granite" variety. The chemical action which is necessarily connected with most culinary operations, owing to the presence of acids and alkalies, makes the character of the containers or the vessels in which cooking is done a matter to be carefully scrutinized. Canned goods and copper vessels have had their turn in the past, and now aluminum vessels have attracted attention. It occurred to the Lancet Laboratory to start a series of investigations as to the extent and way in which various aluminum cooking utensils were affected by the usual articles of food and savory substances used in cooking. All the experiments were conducted "as in the kitchen," so far as the vessels used for cooking were concerned, the food materials cooked in them being reserved for further testing in the laboratory. The conditions studied were the effect on aluminum of water, cold and boiling, of common salt (one per cent. in tap water), of water and acetic acid, the same with the addition of common salt, tartaric acid, carbonate of soda, of bacon, breakfast, and tomatoes with butter, salt and pepper, fried in an aluminum pan, of preparing soup, and of boiling various vegetables—such as onions with salt and pepper, carrots, brussels sprouts and apples, in an aluminum saucepan. The only case in which any result worthy of consideration was attained, was in the use of carbonate of soda, when the metal showed distinct darkening and the solution responded decidedly to tests for the metal. The use of carbonate of soda should therefore be avoided with aluminum vessels, though, as the Lancet report points out, a warning to this effect is frequently issued when aluminum cooking vessels are sold. Some darkening of the metal and the merest traces of aluminum were found in the experiments with common salt, beefsteak, tomatoes, soup preparations, brussels sprouts and apples, but it was declared to be entirely negligible from a hygienic viewpoint in all cases. No

darkening showed and no trace was found with acetic or tartaric acids, with onions or carrots. As for the effect of water no evidence was found of the presence of a soluble salt of aluminum or of suspended particles of the oxide in water boiled in an aluminum saucepan bought in the open market. When cold water was allowed to stand in it for twenty-four hours, however, a white gelatinous substance sweated out, and this was found to contain aluminum and silica. Wet aluminum, therefore, seems to oxidize when left long in contact with the air, so that the leaving of water in aluminum water bottles when not in use is to be avoided. Covering the surface with a film of hydrocarbon oil is recommended to protect the metal against the combined action of moisture and air. The upshot of this interesting and practical inquiry seems to be that the use of pure aluminum cooking utensils need occasion no misgiving as to any possible evil effects.

Hospital Intelligence

CANADA

Medical Men on Board

Dr. D. G. Revell has been nominated by the University of Alberta as a member of the new Hospital Committee.

Floating Hospital

Following the lead of Boston, Montreal will probably provide a floating hospital for young children; a cruising vessel will be obtained.

Leamington Hospital

J. M. Henry and four associates are incorporating with the idea of building a $20,000 hospital in Leamington. It will be open to all physicians.

Cobourg Whirlwind

The new Cobourg Hospital Board and its friends conducted a whirlwind campaign recently, and a very generous amount of money was raised in support of the institution.

Quebec Fight

Fifty-two thousand eight hundred and fifteen dollars have been collected for a new tuberculosis hospital in Quebec City. When the amount reaches $75,000 work will begin.

Why Rags?

The superintendent of the Yarmouth Hospital has sent to the *Yarmouth Times* a list of much-needed articles, which we feel sure will be readily supplied by generous friends: Pillows (any size), table napkins, bath towels, face cloths, combs, kitchen table, white cotton for garments, clothes basket, ice-cream freezer (4-quart size preferred), rags of any sort.

A Fine Mental Hospital

Several visitors to the American Medico-Psychological Association, held at Niagara Falls, visited the new asylum at Whitby and pronounced it fine.

Sun Rooms

The Ladies' Auxiliary of the Berlin-Waterloo Hospital are erecting sun-rooms, which will cost $3,500.

Open-Door Policy

The proposed Howard Park Hospital, Toronto, will allow any doctor to bring and attend his patient in the hospital.

Hospital Seeks Grant

The North Winnipeg Hospital has applied to the city for $30,000. It is a private corporation.

Calgary Also

Calgary also needs $200,000 for its General Hospital, and the city has been asked to give the amount. This has brought up the question of municipal vs. joint ownership, and an agreement to have a joint hospital board has been much discussed. Special legislation will be introduced in the next session of the Alberta Legislature in connection with the change.

A Large Hospital

The Municipal Hospital at Camrose, Alta., has been found totally inadequate to meet requirements, and an auxiliary building, as large as the original, is to be constructed.

Secured Hospital Contract

W. P. Driscoll has secured the contract for an addition to the Eastern Hospital at Brockville, to cost about $100,000. It will be for the executive offices of the institution and an admission hospital.

In British Columbia

The new Provincial Public Hospital for the Insane, at Mount Coquitlam, known as the Essondale wing, has been completed and opened for general use. There have been 340 male patients transferred to the new institution from New Westminster. This relieves the congestion in the local institution.

Cottage Hospital For Oakville

Oakville, Ontario, citizens are planning to establish a cottage hospital. The pleasant little suburb is growing rapidly in population, and will be greatly served by such an institution.

No Loss

No loss was suffered by the recent burning of the Sydney, N.S., Hospital. The patients were taken out without difficulty, and the money loss—$12,000—was covered by insurance.

Ottawa Hospital

The question of municipal ownership in regard to the Ottawa City Hospital is likely to be brought before the citizens within the next year or two. Present hospital facilities are inadequate, and the present Board are asking the city for funds to increase the accommodation.

High Park Hospital

Dr. Wallace Smuck is chairman of the Howard Park Hospital Corporation, established to build an open hospital for the west end of Toronto. The corporation will approach the city for a grant. Toronto has been good to her hospitals during the past few years, having given, for construction purposes, $600,000 to the General, $50,000 to Grace, $100,000 to the Western, $100,000 to St. Michael's, $200,000 to the Tuberculosis Sanitaria, $250,000 to the Sick Children's, besides, during the past three years, having given over $400,000 to them for maintenance. The new hospital is to cost $100,000.

Who Is To Blame?

Hamilton Board of Hospital Governors blame the alleged unsanitary condition of the City Hospital on the Board of Control who, early in the year, cut down the hospital estimates. They now intend asking the city for $200,000 with which to build a new institution.

Up To The Standard

A Committee of Investigation appointed to report on certain charges made against the Victoria, B.C., Isolation Hospital, declare that, while somewhat lacking in equipment, they found it to be well managed, and up to the standard for cities of the same size.

Aldermanic Differences

The Calgary City Council proposed to enact a by-law providing $200,000 to purchase two acres of ground from the Hospital Board, on which to erect a hospital annex. Alderman Garden objected unless the General Hospital Board was reorganized, giving the city adequate representation on the Board.

UNITED STATES

New Detention Hospital

Waterloo, Iowa, is planning a new detention hospital.

Charities or Not?

Denver is investigating its hospitals to learn which ones are really charitable institutions.

Better Salaries

A writer in the *Philadelphia Ledger* finds fault with the meagre salaries paid in the Municipal Hospital in that city. Employees receive $15 to $45 a month, while the superintendent and chief medical officer receive $2,500 and $2,000. The writer says these latter should receive $7,500; the matron $3,600; and trained nurses $75 per month.

Enlargement

The Tuberculosis Hospital of Orange County, N.J., is being enlarged by W. B. Thorne.

New Addition

A contract has been awarded to C. W. Wade, of Roanoke, Va., for construction of a new addition to the Jefferson Hospital, of Roanoke, to cost $25,000.

Tiny Tim Hospital

An effort is being made to raise $100,000 for the erection of a non-sectarian hospital for crippled children in Brooklyn. A Tiny Tim Society, composed of 100 prominent women, has been organized. Nearly $20,000 has already been raised, and it is planned to make a special canvass in November next.

Flower Hospital To Build

Plans have been filed for the erection of a new building for the Flower Hospital, New York, to be used exclusively for private patients. It will be situated on the southeast corner of Avenue A and Sixty-fourth Street and will cost about $140,000. The building will have facade of brick and limestone in the Georgian style, and will be equipped with every possible hospital appliance.

Lack of Harmony

The *Atlantic City Review*, in a recent editorial, comments on the hospital situation there in this wise: "That it is beyond question or the shadow of doubt that the Atlantic City Hospital is not conducted efficiently, thereby eliminating from it a large percentage of public support. The reason that the hospital is constantly calling for funds, and constantly calling attention to its financial deficit is because of the intense dissatisfaction about town. The public is not supporting the institution because it has knowledge of too much that is unsatisfactory in that institution. The internal staff is littered with deadwood, and the day is not far off when it is going to be removed."

Physicians Resign

Six prominent physicians on the staff of the Troy, N.Y., Hospital recently resigned, rather than divide their work with other doctors, as recommended by the head of the institution.

New Hospital Discussed

A new Evangelical Deaconess' Home and Hospital is proposed for Milwaukee. Rev. Paul Goldstein will be superintendent, and Cornelius Leenhouts is the architect.

New Texas Hospital

A new hospital is planned for San Antonio, Texas, to be thoroughly modern in every sense of the word. A feature will be the ambulance service.

A Probe

The press of New Jersey has stated that the investigation into the management of the Tuberculosis Hospital of Hudson County, held in June, revealed gross mismanagement or worse. "Caring for the victims of tuberculosis," says the *Journal*, "is, under any circumstances, difficult and trying, but when facilities are hampered by politics and inefficiency, the problem becomes impossible."

Another Cleveland Hospital

Cleveland is to be the home of one of the most modernly-built and thoroughly equipped hospitals in the Central States upon the completion of the proposed new St. John's Hospital.

The new structure is to be located on the site of the present hospital, 7911 Detroit Avenue, and will have a capacity of 170 beds. The present location is accessible to a large factory district, and one which is constantly growing and expanding.

The new St. John's Hospital building is designed in the Italian Renaissance style of architecture. It will be built of light grey impervious brick and glazed terra-cotta. The interior will be constructed of sanitary materials, and will be fireproof.

Hospital Every 20 Blocks

Dr. Abraham Jacobi advocates a chain of hospitals for New York City—one for every 20 blocks. The small hospital, he maintains, is better for both patient and physician.

$60,000 to Hospital

Ralph Emerson, a retired manufacturer and philanthropist, recently gave $60,000 to the Rockford Hospital, La Salle, Ill., for a new addition.

Contracts Awarded

Saratoga County has awarded contracts to the amount of about $30,000 for the construction of a tuberculosis hospital. That the trend is toward local hospitals for tuberculosis and away from state institutions, except for incipient cases, is shown by the fact that New Jersey, Washington, Illinois, Ohio, Maryland, Wisconsin, Minnesota and Kentucky, besides Massachusetts and Indiana, have local hospital laws similar to the county hospital law in New York

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Hospital Centre

In opposition to the proposal to establish a great hospital on the East Side of New York, between Central Park and the East River, a doctor writes to *The Herald,* recommending a place at the upper end of Washington Heights, which is the highest point on the island.

A Hot Box

Louis White, of San Francisco, is suing St. Francis Hospital for $50,000 damages for alleged injuries to his step-child, who was burned by hot water bottles applied to his tiny body and left there too long by a careless nurse.

Hospital Corner-Stone

The corner-stone of the Volunteer Hospital, New York City, was laid on June 30th. The building will be finished in October.

Do As Rome Does

The County Hospital Building, at Rome, New York, is completed. It has an up-to-date kitchen.

Cost of the County Hospital

It is proposed to build a sanatorium in Hopper's Glen for the care of tuberculosis cases in Albany, Monroe and Erie counties.

Cincinnati City Hospital Cost

Councilman Peck, of Cincinnati, writes to Mr. H. L. Laws, a member of the new City Hospital Commission, in part, as follows:

"It is high time that somebody called a halt upon this unjustifiable and reckless extravagance with the public funds.

"The fact that Mayor Schwab, who was ex-officio a member of your board at the time these plans were adopted, refused to concur in their adoption, is sufficient evidence of the fact that my criticism is not partisan and does not originate under the present administration.

"The cost of your institution ($5,000 per bed) tells the whole story. It costs as much to house each patient in your hospital as if each one were provided with a separate residence of handsome proportions. When we reflect how few families can afford a $5,000 residence, and that you have provided accommodation for patients at the rate of $5,000 apiece, the extravagance of your proposition is apparent."

Whirlwind Campaign

The citizens of Bloomfield, Glen Ridge, Montclair, Verona, Cedar Grove, the Caldwells and Essex Fells organized for a twelve-day campaign to raise $300,000 for the Mountainside Hospital, New York.

For the Friendless

The Home for the Friendless, Pittsburg, has erected a fine hospital in the grounds of the institution.

A Fine Resolution

Dr. Robert Bartlett has recently been appointed superintendent of the Oneida County Hospital by the Board of Managers of that institution. He was selected from among three candidates for the position because of having had practical experience in hospital administration. The members of the board decided that it would not be proper for them to take any position in regard to recommending anyone for appointment by the superintendent, who has the sole power of naming his assistants in the conduct of the hospital. The managers say that they intend that the institution shall be kept clear of politics and all other matters that may detract from the proper running of the hospital in the best interests of those who are inmates and the taxpayers of the county.

Additional Maternity Wards

New buildings have been added to the Maternity Hospital at Auburn, New York. Miss Florence M. Grant is the superintendent.

Three Day Canvass

The Presbyterians of Pittsburg are building a $300,000 hospital for all creeds. The general appeal was supplemented by a special three-day canvass by 50 well-known business men. Trustees, staff physicians, nurses, church men and church women, Sunday School superintendents, teachers, pupils, Christian Endeavorers and King's Daughters have joined forces in this last effort to complete the amount required.

Temperamental Incompatibility

Dr. Zerbing, chief surgeon of the Receiving Hospital, Los Angeles, California, is seeking to have Miss L. B. Miller, a trained nurse, removed from her position in the hospital, according to a Los Angeles paper, on account of "Temperamental Incompatibility." Miss Miller, who holds her position under the Civil Service rules, is resisting the efforts of the doctor. An investigation is forthcoming.

One Way Out

Mr. Wessel, a merchant, of Yonkers, N.Y., got into trouble with the labor union of that town by employing non-union men to work on his building. He squared matters with the union by promising never to do it again, and donating $100 to the two hospitals.

New Buffalo Hospital

A tuberculosis hospital for children, capable of accommodating 25 patients, is to be built immediately by the City of Buffalo. It is hoped to have it ready within a year.

Another Hospital Zone

The City Council of Newburgh, N.J., has designated a city block as a hospital zone, in accordance with a request from St. Luke's Hospital of that city.

A Good Law

The people of Dallas County, Texas, having built a tuberculosis hospital, have discovered that a State bill, which takes effect in December of this year, compels every county of 10,000 population to make hospital provision for all its sick, whatever the nature of the disease. They are therefore now up against the problem of building a large general hospital.

The bill goes on to state that if current funds of the county are not available for such purposes that county warrants and scrip may be issued, or at a special or general election proposition of issuance of county bonds for the purpose of building such hospitals shall be legal, and the bill urges a provision of requisite funds.

An Unjust Tax

The Philadelphia hospitals are looking forward to the final passage of legislation to relieve hospitals and other charities not receiving State aid from the heavy burden of a collateral inheritance tax.

Tonawanda Hospital

The De Graff Memorial Hospital, to cost $40,000, will be erected during the present year in North Tonawanda. The donors of the money have placed the project in the hands of a managing board, one or more of whom will represent the city.

A Wise Precaution

Los Angeles City Council has recently amended its hospital ordinance so as to provide that it shall be unlawful to use for hospital purposes any building hereafter constructed more than one storey in height, unless such building is a Class A structure; and that it shall be unlawful to change or convert any building over one storey in height to the uses of a hospital, sanitorium or sanitarium or asylum unless such building conforms to the provisions of the ordinance relative to construction of such buildings.

Points in Contracts

Saratoga County, N.Y., has appropriated $30,000 for the erection of a tuberculosis hospital. Contracts have been let as follows: For the administration building, $14,615; for an advanced case pavilion, $9,954; for a connecting corridor, $624; for a sewage disposal plant, $2,417. The balance of the appropriation is reserved for the installation of a water system. Other proposed hospitals of similar size may get points from this division of funds.

The German Evangelical Lutheran Churches of Iowa are planning to build a Deaconess Home and Hospital at Marshalltown to cost $75,000. A site for the home has already been purchased for $14,000.—St. Joseph's Mercy Hospital, Waverly, is to be enlarged this summer to about thirty-two rooms. The cost of the addition will be about $20,000.—The managers of the Florence Crittenton Home, Sioux City, have announced plans for the construction of a maternity hospital.—Drs. E. S. Heilman and T. J. Houlihan have arranged to build a two-storey hospital in Ida Grove this summer, to accommodate twenty patients.

Milwaukee Active

A new Mount Sinai Hospital, to cost $100,000, will be built in Milwaukee. Fifty thousand dollars has already been promised, contingent on the raising of an equal amount. A campaign will be undertaken. The Secretary is Leopard Hammel.

Hempstead Hospital

Plans are under way for enlarging the Hempstead, Long Island, Hospital to accommodate about 100 patients. The hospital is under the direction of the Catholic faith, of which Bishop McDonnell is the head.

New Jewish Hospital

Beth David 100-bed Hospital, New York, was opened recently. It is 80 feet by 80 feet and six storeys in height, costing $160,000. The superintendent is Dr. A. A. Berg, formerly of Mt. Sinai. Ten thousand people attended the opening.

Oakmount Sanitarium, the Ontario County (N.Y.) Hospital, has accommodation for twenty patients. The population of the county contains 52,000. Chautaqua County, with 105,000 people, will possibly have a sanitarium. Mrs. E. M. Newton, of Fredonia, has willed $150,000 for such a purpose.

The German Hospital, Brooklyn, is seeking to raise several thousand dollars to purchase an auto-ambulance.

By the will of Mrs. E. M. Newton, a wealthy resident of Fredonia, N.Y., $150,000 was bequeathed for the erection of a tuberculosis hospital for Chatauqua County, N.Y.

A campaign was carried on during early May by the Board of Managers and Trustees of the Todd Hospital and the Trustees of the Carlisle Hospital for a new hospital that will be sufficient to meet all demands of Cumberland and surrounding counties outside of Dauphin, Pa.

It is proposed to enlarge the City Hospital at Binghamton, New York.

Seventy-five thousand dollars has been willed to provide for the building of the Lathrop Corley Memorial Hospital, Cleveland.

A temporary hospital of 175 beds for emergency work has been provided for the fiftieth anniversary of the battle of Gettysburg.

A $50,000 hospital is to be constructed by the Jewish Maternity Association of Philadelphia, Pa.

Dr. Clarence L. Hyde, recently appointed superintendent of the J. N. Adam Memorial Hospital, Buffalo, N.Y., reports a population of 110 patients, all of whom sleep on verandahs. They work 50 acres, raising vegetables and caring for fruit trees. The hospital will have its own supply of milk and eggs.

Central Islip Insane Asylum, New York, is 31 years old. Dr. George Smith has been superintendent 21 years. He began service in the asylum 31 years ago, establishing the colony plan. Dr. Smith has treated 40,000 cases.

A new hospital and dispensary is projected for Bexar County, Texas. Governor Colquitt wishes to see a hospital erected in every county over 10,000 in population.

A hospital doing for the State what the city hospital does for the city is the aim of Dr. L. B. Baldwin, superintendent of the Elliot Memorial Hospital of the University of Minnesota. This young hospital was established in 1909 and is progressing admirably. A service building is to be erected shortly.

Ground was broken for the new $800,000 hospital in Danville, Pa. It is to be called the George F. Geisinger Memorial Hospital.

It is proposed to erect three buildings to cost $100,000, to contain wings for general hospital purposes, also contagious and maternity cases, at Poughkeepsie, N.Y.

An addition is being made to the Flower Hospital, New York City—cost, about $180,000.

Ninety thousand dollars is being spent on additions and installations to the Arlington General Hospital, Philadelphia, Pa.

After July 1 more than twice as many patients as are now accommodated will be able to be treated in the city hospitals of Minneapolis. The completion of the new nurses' home of the City Hospital and the rebuilding of the Children's Hospital buildings will make this possible.

A sewage treatment plant consisting of a modified Imhoff tank, contact beds and sand filters, was built for the Julietta Incurable Insane Hospital of Marion County, Ind., in 1912.

Hackensack, N.J., May 6.—Bergen County is to have a tuberculosis hospital. The total cost will be about $175,000.

The late Dr. Bull's private sanatorium, New York City, has been sold. A store will be built on the site.

A new hospital is proposed for Columbus, Ohio. Much needed.

Recently the Superintendent of the Poor in Suffolk County, which has no tuberculosis hospital, tried to get a patient into a county hospital in another county. He wrote to the superintendents of seven county hospitals, but found that there was not a single vacant bed in any of them that had not already been applied for by some resident of the county owning the hospital. After much delay, however, he did succeed in finding an available bed in the Ulster County Hospital.

No doubt the mortality spoken of occurred, but it is not fair to compare the mortality in an open hospital in a small town with that of a closed hospital in a large city, and it ought not to be allowed to go unchallenged, the statement made here that the death rate is larger in open hospitals in small hospitals, than it is in large hospitals, and I for one feel that the figures and facts in connection with that statement ought to be produced here.

CHAIRMAN: I did not gather that from what Miss Goodnow said. I did not gather from Miss Goodnow's remarks that she was comparing two small open hospitals with two large closed hospitals.

MISS GOODNOW: I did not hear what was said.

CHAIRMAN: The last speaker said that it was not fair to compare the mortality of open small hospitals to the mortality of large closed hospitals, and I was just remarking that I did not think you said that.

MISS GOODNOW: I said that I had been in two open and two closed hospitals.

CHAIRMAN: In regard to the size, how were they?

MISS GOODNOW: Of the two open hospitals one was thirty and one fifty beds, and of the closed ones, one had one hundred beds and the other one thirty beds.

MR. A. O. FONKALSRUD, BROOKLYN: I enjoyed the paper exceedingly, particularly as it pronounced my views on the subject. I have had the opportunity to have been connected with two hospitals, one in the Middle West, close to where Mr. Olson is, and one in Brooklyn. The one in the Middle West was a hospital of about sixty-five beds, in a small town of about 15,000 people, and was an open hospital, and in that connection I will say that if it is a question of putting a hospital on a paying basis, it has got by all means to be an open hospital. It is absolutely futile trying to make a hospital self-supporting and close it, I mean confining it to a small number of staff doctors. The hospital I was connected with out there, as I said, was an open hospital and we never had any trouble from the doctors

that came there to take care of our charity patients. At the end of the year we had anywhere from $6,000 to $8,000 in our treasury. We did not have any Ladies' Auxiliary or Ladies' Aid Societies of any kind. Our ward fee was $10 a week. The highest-priced private room was $25.00, and, as I said, the result was anywhere from $6,000 to $8,000 in excess, a balance at the end of the year, all the results of the patients' fees. No patient was refused because he could not pay, all were accepted. The death rate there was about one-third of one per cent. Later I went to a hospital that is a closed hospital. But understand that the one is in a comparatively small city, the first one I mentioned, of about 15,000 people, the other is in Brooklyn, and the conditions under which the two hospitals are working are, of course, absolutely different in every way. At the closed hospital we have had, since I came, anywhere from $3,000 to $5,000 a year above our expenses, but remember that in order to have that we have a Ladies' Auxiliary that brings us about $5,000 a year. We have an endowment fund of $135,000 that brings us a 5 per cent. interest. We have special donations and contributions that amount to about $3,000, and the City of New York pays about $10,000 to $11,000 to the institution for so-called city patients, so you understand that combining all these together we have a little balance, in a sense. Our death rate in the last-mentioned hospital is about 9 per cent., there is the difference. So that is my experience.

I want to say regarding the management of hospitals, in order to have them paying, or self-supporting, I will say again that they must be open, of that I am certain. We have in Brooklyn any number of private sanitariums, the cause of a great number of private sanitariums being that the hospitals are practically all closed. Naturally, probably 75 per cent. of the good medical men of the city are excluded from hospital facilities. If they take their patients to one of the general hospitals, they claim that their patients are stolen from them, and I presume that in many cases that is correct. I, for one, cannot blame a doctor for not being willing to submit to anything like that. They will go and erect private sanitariums, and, mind you, a private sanitarium is, as a rule, well managed, self-supporting, it pays, it is good business. I will say this,

Personals

DR. H. A. BOYCE, OF KINGSTON, ELECTED SECRETARY

At the meeting of the American Hospital Association at Boston, Mass., a few weeks ago, Dr. H. A. Boyce, Medical Superintendent of Kingston (Ontario) General Hospital, was elected Secretary, to take the place of Dr. J. N. E. Brown, late of Toronto, and now Medical Superintendent of the New Detroit General Hospital. We congratulate Dr. Boyce upon so well-deserved an honor, and know that he will fill his new office with credit to all concerned. The Association loses a mighty able organizer in Dr. J. N. E. Brown, who has done Trojan work in its behalf ever since its inception.

MR. W. J. GAGE, OF TORONTO

THE HOSPITAL WORLD extends congratulations to Mr. W. J. Gage on the honor recently bestowed upon him at the hands of His Majesty King George in his appointment as a Knight of Grace of the Order of the Hospital of St. John of Jerusalem. We cannot say more than that the decoration is heartily deserved. The honor does not carry a title, but it is even a more distinguished one than that of Knight Bachelor in the comparative fewness of those who possess it. There are hundreds of Knights Bachelor, but only sixty members of the Chapter of the Order of St. John, of which Mr. Gage is now a "Knight of Grace."

The order had its origin in Jerusalem and Acre, as an international lay fraternity for the relief of Crusaders, and was later sovereign in Rhodes and Malta. It was expelled from Malta by Napoleon in 1798, after which it was reconstituted, and is now known as the Grand Priory of the Order of the Hospital of St. John of Jerusalem in England. A royal charter was granted to the reconstituted British order in 1888 by the late Queen Victoria, and the first Grand Priors were King Edward VII. and King George V., while Prince of Wales.

The work of the British order is the control of the St. John's Ambulance Association and Brigade, and of the British Ophthalmic Hospital at Jerusalem. Its badge is a Maltese cross of white enamel, with a lion and a unicorn in alternate angles of gold and silver, according to grade, with a black watered ribbon. King George V. is the Sovereign head and patron of the British order, H. R. H. the Duke of Connaught is its Grand Prior, and Col. Sir Herbert Perrot, Bart., C.B., its Secretary-General.

Messrs. Rebman, Publishers, New York City, take pleasure in informing the profession that the International Medical Congress has awarded to them the Gold Medal for the best medical publications.

Book Reviews

Massage: Its Principles and Technic. By MAX BOHM, M.D., of Berlin, Germany. Edited, with an introduction, by CHARLES F. PAINTER, M.D., Professor of Orthopedic Surgery at Tufts Medical School, Boston. Octavo of 91 pages, with 97 illustrations. Philadelphia and London: W. B. Saunders Company. 1913. Cloth, $1.75 net. Sole Canadian Agents, The J. F. Hartz Co., Ltd., Toronto.

The value of this book to the medical man, student or educated masseur depends not so much on the principles of massage outlined in the text as it does on the admirable illustrations, made from photographs, which present at a glance the technic.

A simple, not too technical, diagram of the parts surrounding a joint is first given, then a number of very perfect photo-

graphs of the exact movements used in the massage of this part, with concise and easily followed directions.

The same principle is followed in dealing with massage of the muscles, and of the abdomen, to which is added some useful diagrams of the "points of emergence of nerves" in the head and limbs.

The book is handsomely gotten up, well printed on heavy paper, with large, clear illustrations, the whole being thoroughly indexed.

A. J. J.

Diet Lists of the Presbyterian Hospital, New York City. Compiled, with notes, by HERBERT S. CARTER, M.D., Assistant Visiting Physician to the Presbyterian Hospital, Associate in Medicine at Columbia University, etc. 12mo. of 129 pages. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, $1.00 net. Sole Canadian agents, The J. F. Hartz Co., Ltd., Toronto.

This is a very useful work, not only for the physician, in arranging special diets, e.g., typhoid, diabetes, salt-free, purin-free and the various gastric and anticonstipation diets, but also for nurses and hospitals. We have much pleasure in recommending it to our friends.

M. J. W.

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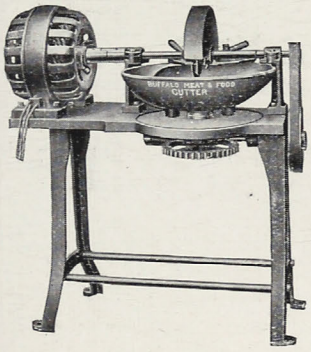
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NEW HOSPITAL APPLIANCES, PHARMACEUTICAL PREPARATIONS, ETC.

An Important Agency

Mr. John Lowrie, formerly Canadian Manager of Wm. Harland & Son, and for the past three years traveller for the Ault & Wiborg Company, of Toronto, calling on the factories in Western Ontario, has joined the sales staff of the Standard Paint & Varnish Company of Windsor, Ontario.

This firm has secured the agency for the United States and Canada, for twenty years, of the Thos. Parsons & Sons, celebrated English varnishes. Mr. Lowrie will have charge of the selling end in United States and Canada of these goods, besides looking after several accounts in Canada for the well-known goods of the Standard Paint & Varnish Company.

The Peerless Water Supply System

The operation of a Peerless Pneumatic Waterworks System, which is so adaptable for use in hospitals, is very simple, and little or no technical knowledge is required to understand it.

In order to explain the system, we will assume that there is located in the basement of a building a perfectly air-tight tank, to the bottom of which are connected two pipes, one to convey water from the pump to the tank, and the other from the tank to the plumbing fixtures in the basement, ground floor, first floor, etc., etc. Such an arrangement constitutes a pneumatic system.

As the water is forced into the bottom of the tank, and begins to displace some of the air, the latter is compressed into an ever-decreasing space, creating a force known as pressure, and if a tap were opened in the basement all of the water in the tank would be forced out by the compressed air again expanding to its normal volume, it having been noted that the delivery to, and the discharge from, the tank are connected into the bottom of the latter, so that the air may not escape from the tank while any water remains in it.

For each pound of pressure indicated by the gauge the water can be forced up through a vertical pipe to a height of 27 inches, therefore 60 pounds pressure will elevate water 135 feet above the tank, so that while all of the water in the tank would be discharged from a basement tap, a less amount would be discharged from the fixtures as at greater elevation.

With an *absolutely air-tight tank*, the contained air can be lost only in one way, viz., its absorption by the water, and as a rule the loss due to this cause is almost infinitesimal. Provision can be made, however, for the supplying of more air when such becomes necessary, by three methods, viz.: The placing at a



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PHYSICIANS AND NURSES, alarmed by recent fatalities caused by bichloride of mercury and other dangerous drugs taken internally by mistake for an antiseptic, are advocating the use of peroxide of hydrogen, which is not only perfectly harmless, but is extremely efficacious as a germicide.

THE CHAIRMAN OF THE HEALTH COMMITTEE of the Chicago Board of Aldermen, the Hon. Willis O. Nances, declared in a public address on June 23:

> "INVESTIGATIONS made by the press and others have shown poisonous drugs are too easily obtained in this city. There is really little excuse for the use of mercury by the public generally. Peroxide of hydrogen or boric acid, neither of which is a dangerous poison, will usually serve the purpose of antiseptics in the household."

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convenient point on the suction of a small stop-cock and check-valve, which may be opened by hand, permitting the entrance of a small amount of air with the water being delivered into the tank.

The second method is by means of a combination water and air pump, and the third method, which, however, need only be considered in connection with systems of a considerable size, is a special air-compressor operated by hand or by machinery.

For further particulars, readers should refer to page lviii of this issue of the HOSPITAL WORLD.

Modified Milk for Babies

The City Dairy Co., of Toronto, have secured from Dr. Gaertner, of Vienna, Austria, the right to use his method of modifying cow's milk for baby feeding and to put out a baby milk under his name.

The method of modification is very simple: those properties in cow's milk which are in excess of those in mother's milk are extracted without otherwise changing the milk. The baby milk is then put into portion feeding bottles, which are sealed and then pasteurized in the bottle. The baby feeds direct from this bottle.

The City Dairy use milk produced at their certified farm, Dentonia, as the basis of Gaertner's Baby Milk.

Certified cow's milk, modified (without adding to or changing its chemical constituents) to suit a healthy baby's needs, pasteurized in a sealed bottle holding one feeding, and fed from that bottle—barring mother's milk, this has the appearance of being ideal.

A New Food Chopper that Cuts or Minces Fine without Mashing the Foods

One of the most valuable machines invented lately for hospital kitchens is a new meat and food chopper that is perfectly clean and sanitary.

It cuts foods, and *does not mash them* the same as machines used heretotfore. It saves from 200 to 600 per cent. of the time and labor. The machine is noiseless, and can be set on any floor; has electric motor attached.

Many hospitals and institutions are already using this machine, and many of them say it is almost impossible to believe what this machine does for a hospital, unless you see it work. This machine is already being used in many hospitals and hundreds of hotels, who find it a very valuable machine for their use.

Managers of hospitals can get a catalogue and full description and full information by addressing the manufacturers, John E. Smith's Sons Co., 50 Broadway, Buffalo, N.Y., and also a list of users.

The New Toronto General Hospital

IS a marvel of completeness to the most minute detail. Nothing has been neglected in the perfecting of the most up-to-date hygienic, sanitary and perfect institution of the kind on the Continent, if not in the world and the Board has the gratitude of the great public at large, not only of Toronto and Canada generally, but of the hospital workers of the entire country, who regard this as a model.

The drinking water supplied to the patients is produced by the TRIPURE Sanitary Water-Still process, in use by the United States Government in their Army and Naval Hospitals and Departments, War Vessels, etc.

This water is distilled and triply purified and oxygenized during vaporization, making it potable, palatable and delicious—really an artificial rain water—and is absolutely pure and sterile—so pronounced by the World's Congress on Hygiene and Demography.

TRIPURE Water will be frozen in Carafes in the most up-to-date manner by a Kent Ice Machine, thence to be delivered at the bedside of individual patients.

The installation of these two standard plants in a building specially built and designed for them demonstrates the infinite attention to detail and convenience of operation and to the comfort of patients which has been lavished upon the work.

The Sanitary Water-Still has been adopted, as it is the only Water-Still which returns to the vapor all the oxygen removed in the boiling, thus doing away with the flat and insipid taste found in all other distilled waters. The cost of operation is practically nil and the space occupied—often a desideratum in compact work—is no more than used by an ordinary kitchen hot water tank, and requires no expert care or attention.

The Sanitary Water-Still Co. of Canada, Limited, is prepared to figure on all hospital work and furnish apparatus producing from 125 gallons per 24 hours up to 10,000 gallons.

Address, 136 John Street, Toronto, Ontario,

Telephone Adelaide 420.

Sanitary Water-Still Company of Canada, Limited

"Peerless" and Multiple Atomizers

The Hospital Rubber Co., whose Canadian office is 37 Notre Dame Street, Montreal, manufacture a line of atomizers that are worthy of notice. Physicians know how awkward it is, in many cases, to have to devote both hands to the use of the atomizer. The Hospital Rubber Co. have overcome this in turning out their "Peerless" atomizer, which is *held and operated with the same hand.* All rubber parts have been eliminated, there being a steady, even air pressure, with a spray under perfect control. The same firm manufacture the "Multiple" atomizer, three fluids being in one bottle, a sterilizing fluid and two medicinal solutions, ready for immediate use, the operator being able to change from one fluid to another by the simple turn of a button.

The "Peace Patent" Metal Weather Strip

For use in institutions, the Peace Strip is one of the strongest and most effective weather strips on the market.

It excludes all draughts and dust, ensures thorough ventilation, and stops all rattling of windows.

It is one of the most perfect equipments for windows and outside doors of hospitals, public buildings and private residences.

For particulars, apply to William Peace Company, Limited, Bank of Hamilton Bldg., Hamilton, Ont., or to the Toronto Manager, James Everett, 140 Beaconsfield Avenue, Toronto. Phone Parkdale 2148.

Hospital Flooring

The Seaman Kent, Limited, whose factories are at Meaford and Fort William, Ontario, and St. Agathe, P.Q., manufacture a line of hardwood flooring under the name of "Beaver Brand." It makes a beautiful floor, and has already been adopted in a large number of hosiptals, including the General Hospital at Montreal, the general hospital at Oshawa, Hotel Dieu at Kingston, Isolation Hospital at Ottawa, St. John's Hospital, Toronto, and the Hospital for Sick Children at Toronto. These facts are worth noting.

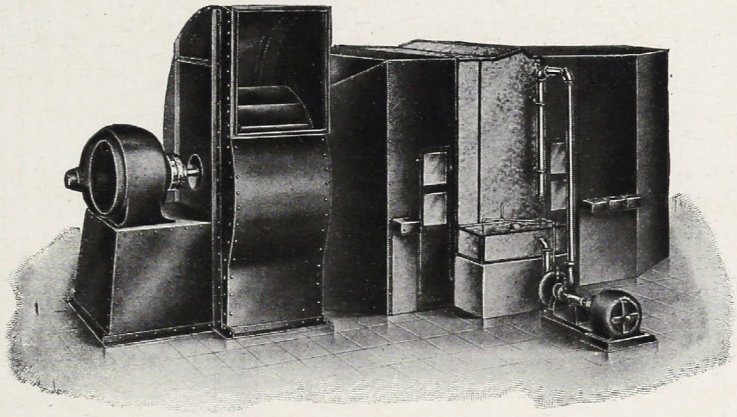
White Glaze Wall Tiling

In the past it has been most difficult to obtain a white glaze tile that does not craze, especially for use in public buildings. Hospital superintendents should remember that such is the case no longer. The Lantry Co. of Bridgeburg, Toronto, and Buffalo, N.Y., can supply a wall tile *guaranteed not to craze, making a specialty, also, of non-absorbent floor tiling for operating room and general hospital work,* and special sanitary terrazo cove bases and stairs. *Nuff sed.*

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Steel Plate Fan with Direct Connected Motor, Tempering and Re-heating Coils, and Air Washer, which is operated by an Electrically Driven Centrifugal Pump

This Fan is the ultimate design of the Multivane type of Fan Construction, and is now specified by all the leading Architects and Contractors. It is the only Fan equal to present conditions of ventilation, and when operated with our improved system of Air Washing it is admitted to be the most modern and approved production in the Fan World.

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Cement Plastering Best Fireproofing Material

Within the past ten years radical changes have been made in construction of hospital buildings, both in appointment and in protecting against fire. The most important to the general public is the protection of the patients as well as the property from the terrible results of a conflagration.

Several different styles of construction have been used in latter years with more or less success in buildings of this nature, but the system conceded by all authorities to be the best yet produced is by using false ceilings of metal lath plastered with cement mortar hung from the floors above, thereby giving absolute protection to the floor and its supports. The partitions are constructed in much the same way as the ceilings and are plastered to any thickness desired with the same kind of material, these can be made either solid or allowing a hollow space in the centre as a nonconductor of sound from one apartment to another, and need not be more than three inches in thickness, thus saving a considerable amount of floor space as compared with partitions of the old methods. By the use of this system a most thorough scheme of heating and ventilating, which is most essential in hospitals, can be installed without the unsightly metal ducts, pipes, etc., being exposed to view, these are hidden above the false ceilings or in the partitions without the least danger of igniting any inflammable material, it also confines the fire and smoke, if the furniture or other articles should catch fire, to the apartment where the fire originated, in this way protecting patients from severe nervous strain, etc.

Several most severe fire tests have recently been made of this method, and the cement mortar has absolutely withstood fire and water at temperatures far in excess of any generated by the most fierce fire possible. Cement plastering on any surface is the hardest and most durable material for plastering known and is best to be used in all public buildings, or where the plastering is exposed to severe usage in any building. As to cost, it can be applied as reasonably as any good plasters now in use.

Hospital Equipment

Attention is called to the page announcement of The Hospital and General Contracts Co., Ltd., 25 to 35 Mortimer St., London W., England, and which appears on page vi of this issue of THE HOSPITAL WORLD. This firm make a specialty of filling large hospital contracts, not alone for hospitals, but for asylums, dispensaries, sanatoria, and institutions of every kind. They carry a full line of sterilizers, surgical dressings, ward lockers, hospital and invalid furniture, in fact everything required by the most modern institution. In considering placing an order with this firm, hospital purchasing agents in Canada should remember the advantage of the British preferential tariff.

SANITARY BRICK WALLS
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MODERN HOSPITALS

Prominent Hospitals, Asylums and Homes, etc., erected for over twenty years, stand up in evidence of the permanent value of

"AMERICAN" ENAMELED BRICK

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When there are taxes to be paid.

What is it that is a first charge on property? Taxes.

What are Taxes? A contribution levied by a community upon its own property in order to pay the cost of government.

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THEY WILL YIELD FROM 5% TO 7%

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The Laboratory

Dr. Wm. Osler's presidential address at the British Hospitals Association Conference at Oxford, quoted at some length in THE HOSPITAL WORLD, August, 1913, made a strong point of the imperative need in modern hospitals of well-equipped chemical, bacteriological and pathological laboratories.

The new serological work in particular demands the assistance of substantial, practical centrifugal machines. This demand is being adequately met by the International Instrument Co., of Cambridge, Mass.

Cork Tiling for Hospital Floors.—This Tiling is made of pure granulated cork and cork shavings. The cork is highly compressed in a steel mould and then enters an oven heated by electricity. This heating liberates a natural gum in the cork, which acts as a binder, thus doing away with the necessity of using a foreign substance for this purpose.

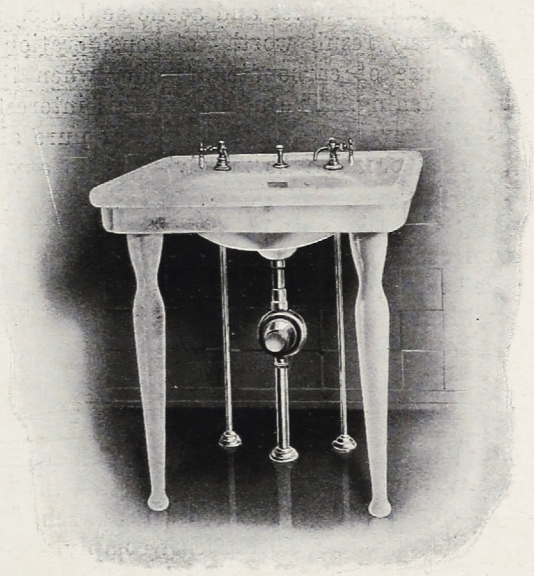
We have no hesitation in saying that cork tiling is an ideal floor for hospital work. Cork being a non-conductor, a floor of this kind maintains an equable temperature all the year round. It is quite odorless, and is not slippery. It is almost noiseless, and although extremely durable is very easy on the feet, as the cork still retains a certain amount of resiliency. Above all, a floor of this kind is sanitary. The floor is laid in blocks of various sizes, the joints being made with a special waterproof cement under pressure. The surface of the floor is, therefore, absolutely smooth, and contains no crevices which might harbor dust, and the floor is easily washed with cold water. This flooring is obtainable from Robinson Bros. Cork Co., Limited, Lumsden Building, Toronto.

Cactus Grandiflorus

Thirty thousand physicians, graduates of all schools, were recently asked their opinions as to the vegetable remedies of greatest value in their practice. Of the 10,000 responses Cactus Grandiflorus received 6,239 votes (*Journ. Am. Pharm. Assoc.*). It was mentioned oftener than any other drug, officinal or non-officinal. This reminds us of Cactina Pillets, which were introduced to the pharmaceutical and medical professions in 1889 by Mr. Sultan, of the Sultan Drug Company. This is the original definite product of cactus, presenting the drug in a constant and reliable form; and the thousands of physicians who have used it in their practice for the past twenty-four years have attested to its undoubted value as a cardiac remedy of great usefulness in the treatment of functional heart troubles. As the makers of Cactina Pillets have consistently advertised this product in the legitimate medical press, it would seem that their great faith in the drug is now justified in an ample manner.

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Aluminum Kitchen Utensils

The increasing use of aluminum for kitchen purposes brings to mind the controversy that a little while ago raged around the use of enameled ware, particularly of the granite variety. The chemical action which is necessarily connected with most culinary operations, owing to the presence of acids and alkalis, makes the character of the containers or the vessels in which cooking is done a matter to be carefully scrutinized. Recently, the *London Lancet* started a series of investigations as to the extent and way in which various aluminum cooking utensils were affected by the usual articles of food and savory substances used in cooking. All the experiments were conducted "as in the kitchen," so far as the vessels used for cooking were concerned, the food materials cooked in them being reserved for further testing in the laboratory. The conditions studied were the effect on aluminum of water (cold and boiling), one per cent. solution of common salt, of water and acetic acid, etc., etc. The only case in which any result worthy of consideration was attained was in the use of carbonate of soda, when the metal showed a slight darkening. The upshot of this interesting and practical inquiry, however, was that the use of pure aluminum cooking utensils need occasion no misgiving as to any possible evil effect.

The Ware Mfg. Co., Limited, of Oakville, manufacture a full line of aluminum cooking appliances, and the attention of our readers is directed to page xv of this issue, where the Company's announcement will be seen.

A Valuable Diet in Diabetes

If a physician prescribes "Gluten Flour" as diet for diabetic patients, he expects, and has a right to expect, that the manufacturer or dealer from whom the patient procures such a product, supplies him with flour which will at least comply with the requirements of the United States Pure Food Law, which demands that a "Gluten Flour" shall contain at least 35% of protein.

There are flours sold as "Gluten Flours" which contain only about half this amount. Such substitutes are liable to be of much detriment to a sufferer from this malady.

After long experience in the manufacture of high-class cereal sanitary specialties, Farwell & Rhines, of Watertown, N.Y., have placed upon the market a genuine Gluten flour containing about 40% of gluten, which has no superior in this country or abroad for all uses, as a flour in marked cases of diabetes.

This Cresco flour has for many years proven a boon to the physician in his treatment of acid and intestinal dyspepsia, carrying a medium percentage of gluten attractive and palatable for all uses in such cases, and mild forms of kidney and liver troubles.

The Hospital World

BUFFALO, U.S.A. TORONTO, CANADA LONDON, ENG.

An International Journal published in the interests of Hospitals, Sanatoria, Asylums, and Public Charitable Institutions throughout America, Great Britain and her Colonies.

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Vol. IV TORONTO, NOVEMBER, 1913 No. 5

Editorials

THE CANADIAN HOSPITAL ASSOCIATION

THE seventh meeting of the Canadian Hospital Association is a matter of history—the story of which will interest hospital workers one hundred years hence infinitely more than it does us, who are too busy with the writing and the toiling to properly note passing events.

It was a fine success. Dr. H. A. Boyce and Dr. Helen MacMurchy supplied the dynamic.

The infant association is able to walk well: its future is assured. Our American cousins came nobly forward: Kavannagh, the Irish fighter from Brooklyn; Howell, the expert in hospital business methods of the New York Hospital; Wayne Smith, the all around hospital man of the friendly South; Stratton, the rising hospital architect of Detroit; Miss Charlotte Aikens, whose deep interest in nursing problems affecting the common people is so well known; Miss Goodnow, the hospital planning expert of Boston; Mr. Richard Bradley, the practical man of affairs, who is focussing his attention on household nursing problems; and Dr. J. A. Hornsby, the well-known authority on the modern hospital; all gave hearty and much valued assistance to make the meeting historical.

Dr. C. K. Clarke, Dr. Haywood, Miss Gunn and other Toronto General officials were most kind in arranging for the meeting-place in the great Canadian institution. They, with the trustees, gave a pleasant reception in the new Nurses' Home.

The attendance was splendid; the enthusiasm fine, and all the papers most informative. We shall take great pleasure in reporting the papers, publishing most of them fully and commenting further on the great gathering editorially.

GIVING—WITH STRINGS

THE superintendent was relating a bit of hospital good luck.

"He has given us one hundred thousand," he said, "and the best of it is there are no strings to it."

The superintendent's comment was a naively uttered appreciation of the value of an unconditional gift. If "he who gives quickly, gives twice," possibly he who gives unconditionally gives twice also.

One form of conditional giving is amusingly burlesqued by Stephen Leacock in his *Sunshine Sketches*:

"When Mullins had finished speaking, he took out a fountain pen and wrote a cheque for a hundred dollars, conditional on the fund reaching fifty thousand. And there was a burst of cheering all over the room. Then up sprang George Duffy and wrote out a cheque for another hundred, conditional on the fund reaching seventy thousand. You never heard such cheering in your life. And then when Netley walked up to the head of the table and laid down a cheque for a hundred dollars conditional on the fund reaching one hundred thousand, the room was in an uproar. A hundred thousand dollars! Just think of it! The figures fairly stagger one! To think of a hundred thousand dollars raised in five minutes in a little place like Mariposa!

"And even that was nothing. In less than no time there was such a crowd around Mullins trying to borrow his pen all at once that his waistcoat was all stained with ink. Finally when they got order at last and Mullins stood up and announced that the conditional fund had reached a quarter of a million the whole place was a perfect babel of cheering. Oh, these Whirlwind Campaigns are wonderful things!"

The second form of conditional giving consists of a gift carrying stipulations and restrictions as to

how, where, and for what specific purpose the money donated is to be applied.

Any large philanthropy is usually controlled by a board of trustees or governors who give voluntary time and service, and become experienced in the needs of the institution.

This is especially true of the public hospital, the trustees of which are usually men of standing in the community, and of marked executive ability, and therefore well fitted to administer any funds left in their charge. It is also directed and served by men who have a thorough technical and professional understanding of its requirements. They know its immediate wants and in what direction a large money gift may be best applied.

That the man who donates his money to a hospital has a right to make what stipulations he chooses concerning its disbursement is generally acknowledged. That he has equal right to give without such restriction no one will deny. In either case it is a gift most worthily bestowed. But possibly the greater service will be rendered by the freer gift—the gift without strings.

THE HOME NEED

THE August number of the HOSPITAL WORLD published an excellent paper, read by Miss Aikens before the Wayne County Medical Society of Detroit, on the care of the sick in homes of moderate means, in which the writer goes very fully into this subject,

which has been under serious consideration in the professional and social service work for the past year or two.

Miss Aikens discusses all aspects of the question —that of the nurses, of the hospital and of the home, the last, of course, being the chief factor.

We have not space here to quote at any length from this thoughtful article, but the author touches the crux of the question when she says:

"We have for years tried to separate the patient from the home in our planning for him, but in the majority of cases he refuses to be separated—or she refuses, for the problem is most acute when the mother of the family is the patient. We shall never make progress until we consider the care of the patient in the home, and the care of the home in sickness, as *two sides of one and the same problem.* The mother with little children will not willingly leave those little children and her home to go to the hospital, unless the illness be of a quite serious nature. She rightly asks to be considered in connection with her home and her little ones, and cared for there if possible. She offers all she can afford for the kind of worker who will care for her in her home, and it should be the business of some organization to see that she gets what she asks. We have tried to offer her a commodity at three and a half or four dollars a day, when what she wanted was a different commodity at one and a half or two dollars a day—which is just about as sensible as offering a farmer a valuable race horse to do his work when he needed a general-purpose animal."

Miss Aikens believes that the system of Household Nursing Bureaus founded by Richard Bradley, whose able paper on the subject appeared in the June HOSPITAL WORLD, is the first organized effort to occupy this field. The care of the sick in the home,

and the care of the home during sickness, is the undivided purpose of this organization.

The methods, as outlined by the bureau, are, first, the establishment of a local board; second, a central local office; third, a corps of workers of three different grades—a skilled graduate nurse, an attendant nurse of one or more years' training, and a domestic helper. These are sent out under the supervision of a graduate nurse who acts as supervisor, and who works in conjunction with the visiting local physician.

"When a call comes it is the business of the head nurse in charge of the office to determine, in conference with the physician or family, whether a graduate nurse is needed, and for how long she is likely to be needed, or whether an untrained or partly trained nurse who will assist with the care of the home will more fully meet the needs of the case. If a skilled graduate nurse is needed for a few days to tide over a crisis, or to administer special treatment, she is sent for as long as is necessary, and replaced by a less skilled nurse when such will fully meet the needs—the untrained worker always being under the general supervision of the organization, and supplemented when necessary by the skilled nurse."

If help in household work is required for the time, the Bureau undertakes to supply that need, since it is believed that "in most communities there are plenty of women who can leave their homes for a few days or for a few hours each day to assist in this way during sickness, who would neither go out to regular domestic service nor undertake nursing."

The formation of a Household Nursing Bureau requires a small amount of capital, but it is organized on a business basis, and is expected to be self-sup-

porting. The fees are moderate but definite. The plan is capable of great expansion, but in its present stage of development it is a splendid effort to cover a large field of social endeavor.

It is to be hoped that Miss Aikens' thoughtful paper will receive wide publicity.

THE PASSING OF DRUGS

THE first step in the treatment of a case is to make a diagnosis. That being made, seven cases out of ten will recover by the *vis-medicatrix naturae,* if the physician will but remember the warning, *primum non nocere.*

Oliver Holmes once said that when a young doctor commences practice he has twenty drugs for every disease; after practising twenty years he has one drug for twenty diseases.

Richard Cabot and his disciples are supplying social service in place of drugs. Fresh air and sunlight are taking the place of iron; rest and proper occupation for cardiac cases are supplanting digitalis. Kindly advice and practical help to the neurasthenic are administered instead of bromide of potash; lessons in cooking to the wife instead of a stomachic mixture to the dyspeptic husband.

Vaccines and serums are rational preventives or curatives for a considerable number of specific infectious diseases. One big dose of arsenic will cure cases of syphilis and some other parasitic blood infections.

But the day of the big pharmacopeia with its

multitudinous tinctures, pills, infusions and the like, is passing.

What medical student does not recall the terrible grinding required to memorize the immense amount of stuff in the old Materia Medica!

The rapid evolution is due largely to the therapeutic nihilists.

In all up-to-date hospitals, the drug bill should be rapidly diminishing.

THE LOW PAVILION

Mr. Saxon Snell in a recent number of an English architectural magazine struck one or two new notes.

He is of the opinion that the day of the sanitary tower is past. He also strongly presents arguments in favor of the spread-out one-storied pavilion in hospital construction. The Germans have adopted this principle in the construction of one of the world's leading hospitals, the Virchow in Berlin.

Mr. Snell points out that the one story pavilion may be cheaply constructed, since the walls and roof may be comparatively light, and no stairs are to be built—or climbed. It takes twenty times as much energy to mount a stairway as it does to walk the same distance on the level. There are no elevators to construct or maintain. The danger from fire is slight. This plan facilitates the work of getting patients out into the grounds, where, the writer maintains, they are better and safer in various ways than when placed on high balconies or roof gardens.

Where the hospital is large, he admits that this form of construction means more ground space, but a hospital site may be chosen where land costs less than does the construction of extra stories.

Such construction involves longer distances for the doctors and staff to travel in the discharge of their duties, but this he claims is offset by the less energy expended and less fatigue involved.

Mr. Snell makes a number of good points in favor of the one story building. There are advantages in the two and three story hospital however. There is usually more sunlight, and consequent brightness on dark days: greater warmth and less possibility of dampness on wet days: and in our northern hospitals light and heat are important hygienic as well as economic factors. There is also greater economy in general administration.

CONCERNING A COMMITTEE REPORT

It was a great disappointment to many who attended the recent Boston meeting of the American Hospital Association that the report prepared by the committee on the grading of nurses was not presented and thoroughly debated and adopted.

Unfortunately the committee since its appointment, had held only one meeting at which the subject was well considered and fully discussed. A second brief convening took place on the eve of the annual association gathering, at which it was decided that, owing to the complexity of the subject, and the

many interests involved, it would be wise to report progress, ask that the committee be reappointed and seek the opinion of the state medical and nursing organizations, as well as of hospital authorities. The committee would then be qualified to present to the association at its next annual meeting a report covering fresh viewpoints and thoroughly matured.

The committee was not agreed in entirety upon the report as it stood, and certain members felt that if presented in its then form the report would not carry—or in event of so doing would cause a marked dissension in the association.

The non-presentation of the report, resulted, unfortunately, in the loss of discussion of the very valuable papers given by Miss Riddle and Mr. Bradley.

The subject was revived, however, at a later session in the Question Drawer, which was so delightfully and wittily replied to by Dr. Charles Drew, of Worcester.

A fear expressed by a few interested members that the question has been shelved, is groundless in view of the fact that the money appropriation granted the committee for the present year will enable it to meet twice or more; also the committee has been strengthened by two additional members. The temper of both the president and the committee toward this important subject assures the association that a matured report may be expected next year—one that will commend itself to the good judgment of the entire membership.

THE RESIDENT SYSTEM

A FEW of the larger and more progressive hospitals have adopted the system of appointing as residents men who have had a couple of years experience as internes. These residents serve from two to five years in the department to which they have been appointed. Such men are of great value to the hospital, invaluable to the chief, and obtain such a degree of excellence themselves as to become, at the end of a five year term, experts in the subject which they have so closely studied.

Such men are needed in every great hospital, being available for any serious emergency work, and for the carrying on of the chief's work in the latter's absence.

Each resident can supervise the work of the internes appointed to the service, and can be of marked assistance in training both internes and final medical students in the best methods of conducting examinations of patients, of history taking, of treatment and research work.

In most instances these internes develop into assistant residents, and later into residents. All medical students should aim to become internes in some hospital. And if they aspire to become eminent in their profession they should also strive for a residency.

Original Contributions

PRESIDENTIAL ADDRESS*

H. A. BOYCE, M.D., PRESIDENT.
Superintendent, Kingston General Hospital, Kingston, Canada.

Fellow Members of the Canadian Hospital Association:

Doubtless you know the Seventh Year is one of the critical periods in a child's life.

Perhaps some of us do not know the struggles that this child has passed through during the year in order to live. Weakly and sickly during the spring and early summer, his health improved as the autumn drew nigh, till now he is as robust as any other organization in the country.

Surely the number of hospital workers here this evening demonstrates beyond a peradventure that this Association must survive. But in order that this may be an accomplished fact each and every one must do their part in the upbuilding of what eventually will be a mighty organization throbbing and pulsating with that life and energy, sufficient to mould public opinion in such a way as to work mighty changes in the hospital field during the next decade.

The clarion notes of the trumpet have been sounded from the Atlantic to the Pacific. Those who have heard the call are with us this evening, gathered in this Clinic Hall of one of the greatest hospital buildings of America.

A glance at the programme will convince the most sceptical of the loss which will be sustained by those who are not privileged to be with us.

Right here and now I wish to state that I consider it a very short-sighted policy on the part of any board not to say to their Superintendent: "We want you to go to the meeting of The Canadian Hospital Association and find out what you can about the best methods of caring for the sick that come to the Hospital." It will be a change from the steady grind. They will return with renewed vigor and with new ideas, which will more than compensate for the little money spent in sending them

* Delivered at the Canadian Hospital Association Meeting, Toronto, October 20th, 1913.



THE NEW TORONTO GENERAL HOSPITAL, WHERE THE CANADIAN HOSPITAL ASSOCIATION MET

to the meeting. An individual who works eleven months of the year is more useful to a hospital than one who seems to work twelve.

Many thousands of the people's money has been saved by sending Superintendents to these meetings. Because they learn better methods of finance; better methods of caring for the sick, thus attracting those who are sick to the hospitals which they represent. Ladies and gentlemen, the day is not very far distant when the people of this country shall demand that Hospital Superintendents shall know the ways and means of making a dollar produce the maximum of efficiency in hospital work. Then and not till then shall the Hospitals of Canada take their proper place among the institutions of the world.

There is another side to this matter we have been discussing. Are we making these meetings worth while? We are free to confess that they are not all that they might be. But the very fact of Superintendents getting together and discussing the problems that are perplexing them make these meetings worth while. Further, one gets the opportunity of visiting other institutions and observing how they do things.

Mr. Olson of the Swedish Hospital, Minneapolis, Minn., told us at the Boston Convention of the American Hospital Association many things that would enable us better to finance our institutions. He said: " I took charge of our hospital some few years ago. At this time the patients were housed in a small dwelling. Since that time we have spent one hundred and fifty thousand dollars, or thereabouts, in new buildings." Further, he says: " We never had a deficit. About this time everybody began to sit up and take notice. For, as you know, General Hospitals usually have deficits. They shouldn't, but they do." He further stated in order to make a hospital self-supporting " We must watch every source of revenue. Keep your fingers on it continually and do not let anything escape, because it is no injustice to a person who beats you, and it is a gross injustice to the people who are helping to support your institution." He says: "No one is going to thank you for distributing your product for less than cost. If you think your patient can not pay nine dollars a week for his care, charge those who can pay full price and make that price large enough to give your institution



INTERIOR SURGICAL WARD "TIMOTHY EATON MEMORIAL," NEW TORONTO GENERAL HOSPITAL

a just and good living and leave something to surplus, not to distribute to shareholders, but which you can distribute to poor patients who can not afford to pay the price."

These are some of the points that make attending Hospital Association meetings worth while.

Another question which one may ask is: What has this Association done in the way of bettering the conditions of the patient?

More modern and fireproof hospital buildings are being constructed. This beautiful and modern building is a good example of this. Patients are being better protected in the way of better fire appliances. Better clinical records are being kept, an intensive study of which is leading to better methods of combatting, preventing and curing disease. Improved methods in operating room construction and technique have led to more rapid and surer results in surgery.

Social Service workers have been able to relieve the anxiety of the poor patient by seeing that those at home are properly cared for. This, of course, leads to more rapid and sure recovery. These with many other points have made these meetings of value to the patients of the hospitals which we represent.

FUTURE WORK OF THE ASSOCIATION.

Along what lines must this Association develop to be of most benefit to the patients and the community?

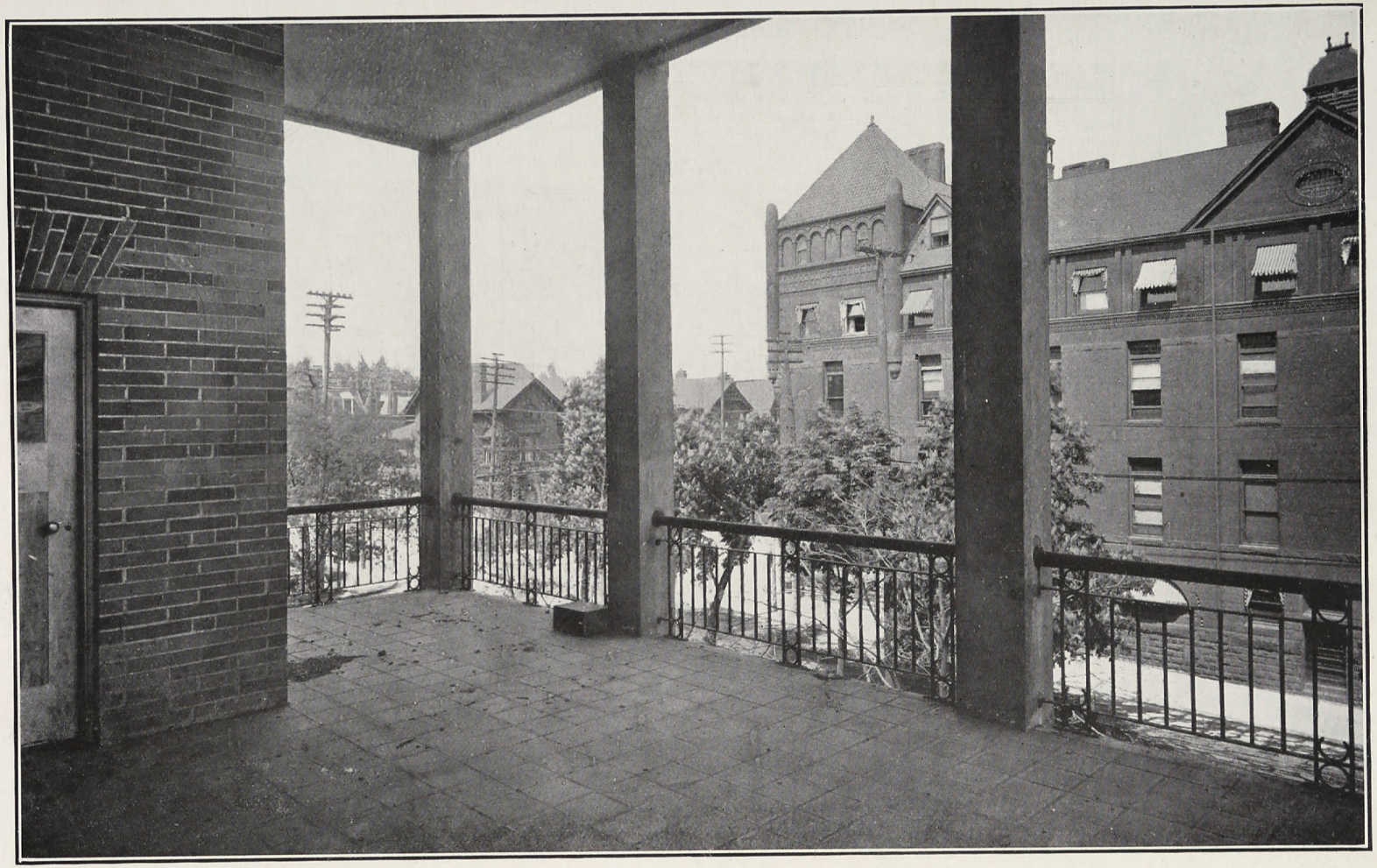
It has seemed to the writer that one of the lines along which we should develop is in the proper course of training of Hospital Superintendents. Doubtless much needless expenditure would be saved and much friction if there was some one to take up the work of the Hospital who has had previous knowledge of the work from living in the institution.

PREVENTION OF DISEASE.

Perhaps one of the greatest benefits this Association can be to the community is to see how many people we can keep well.

Miss Aikens, in a very able paper delivered before this Association last year, showed how this might best be accomplished.

In order that there may be efficient work in the prevention of



PUBLIC WARD VERANDAH, NEW TORONTO GENERAL HOSPITAL

disease the public must be educated. Provincial Boards of Health may make rules and regulations, but unless these are carried out the results will be nil.

We are pleased to say that there have been appointed Health Officers who devote their whole time to the work. This doubtless in itself will work a wonderful change in the health of this country. But still municipalities are employing Health Officers at a salary that would not pay for a month's board in a private house.

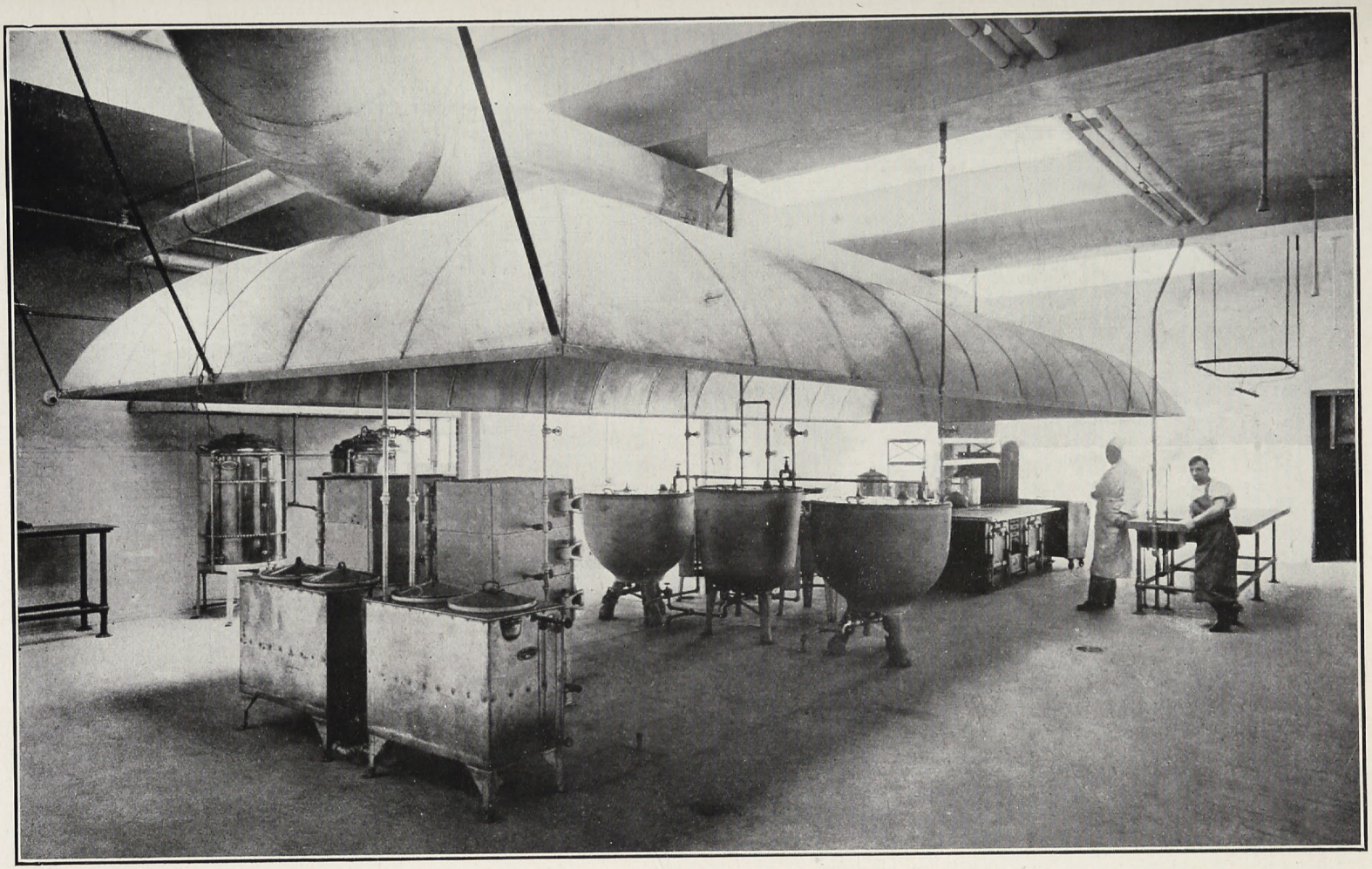
A doctor would be a fool if he did things which would turn his practice away from him. So we find municipalities are getting just what they pay for. The need is for Health Officers who do not have to depend on their practice for a living.

There would be plenty of work for them to do in the rural districts. They could be employed in giving illustrated lectures on Health Topics in different parts of the community. Further they might be employed in getting out illustrated pamphlets on the way to prevent disease. Again they might be employed as Medical Inspectors of school children. It is evident to each of us that if this were done we should be able to lessen disease in the rural districts. Why should we not?

I can remember when I was teaching a country school a bright girl who used to go to visit an old lady near by, who had a chronic cough, which proved to be tuberculosis. About midsummer this little girl became ill, eventually dying with generalized tuberculosis.

A few months afterwards the old lady's daughter went to business college. She had not been there long when she too succumbed to the tubercular meningitis. These two girls are gone—the old lady is still going about sowing her germs.

I should like to give an illustration of another case. A little child was taken ill in one of the back parts of Ontario. The physician was called in to diagnose the case, as the child had by this time developed a scarlatiniform rash. The child was given some fever mixture and the parents were told that the baby would be alright in a few days. The little one recovered and was taken in a short time to visit its grandparents. During its stay here two aunts of the child developed scarlet fever. In five days' time one of the patients had succumbed to this disease.



KITCHEN, NEW TORONTO GENERAL HOSPITAL

This child's case was passed over as being one of scarlatina. If the people had been educated that scarlatina in the one case may mean a very severe type of scarlet fever in another case—this calamity would not have happened. I am sure these cases could be duplicated many times in this fair province of ours.

It is our duty as hospitals to scatter literature on these topics throughout the community in which we live. There should be some one to instruct the patients on the different health topics before they leave the hospital.

Further we must do our utmost to bring about every change that will lead to the prevention of disease in the community.

I believe we should have visiting nurses to go out in the different parts of the country to look after the sick poor, who have to stay at home. These nurses at the same time could instruct those in the household in the methods of prevention of disease.

There should also be school nurses in the rural communities. These nurses could wield a mighty influence for good in the different places which they would be called upon to visit. Many epidemics of contagious diseases would be avoided. The nurses could give very valuable instruction to mothers in the community as to the best methods of caring for their infants and children. Other ways of keeping people well are to give them pure water and pure milk. The epidemics of typhoid in this country have been a positive blot on its good name. I am informed there were as many cases of typhoid in Ontario last year as there were in the whole of Germany. Is it not time that our hospitals were doing something to educate the people?

But we are glad to say conditions are being improved. We may rest assured that many municipalities will not incur the necessary expense until the public press them to do so.

With regard to milk, there should be rigid inspection of dairies and regular bacteriological examination of the milk. Further, cows should be tested for tuberculosis. This would save the lives of many infants in the towns and rural districts.

Tuberculosis reaps a rich harvest every year. What are we as representatives of hospitals doing to prevent the spread of this disease? Many organizations are trying to limit its spread, but we are sitting idly by while thousands are perishing. We shall



THE CAWTHRA MULOCK OUT-PATIENT DEPARTMENT, UNIVERSITY AVE., NEW TORONTO GENERAL HOSPITAL

make very little headway until each doctor reports these cases. Advanced cases must be isolated. If we allow these to go about spreading their germs all over the country, how can we ever expect to prevent the spread of this disease! Impossible!

These things cannot be brought about in a day; it will take some time to get the public educated. How much is our association doing along this line?

There is another line along which this association may do a great work. That is to try to limit the sale of certain patent medicines, which contain morphine and cocaine. Also to try to prevent the spread of literature, the reading of which makes young people think they have every ailment in the medical dictionary. In a vain attempt to get rid of some trifling symptom they fall a prey to the patent medicine quack. After taking the treatment for some time they find no improvement, they drift from one to another, eventually becoming nervous wrecks. These persons ultimately become dope fiends.

Another line along which much good might be accomplished is in the standardization of hospitals. Dr. Hornsby in a very able paper discussed this subject at the Boston meeting of the American Hospital Association. I hope you will all read Dr. Hornsby's paper in the report of the Boston Conference.

Further I believe there should be in the employ of the Government a Hospital Architect. A man who knows hospital architecture. He, together with the Inspectors of Hospitals, should pass on and criticize all plans of institutions before they are allowed to be built.

There are a number of buildings being erected to-day which are little better than fire-traps. For the sake of a few paltry dollars let us see to it that our patients are housed in fireproof buildings.

I believe if the hospitals of this country were constructed according to the plans of a competent architect there would be sufficient money saved to make them of fireproof construction.

Ladies and gentlemen, then and not till then shall this country have hospitals constructed in such a way as to give the maximum efficiency with the minimum of energy. Nurses are to-day walking miles and miles every week through faulty construction of institutions which have been built to please some donor or some faddist.



ENTRANCE TO THE SHIELDS EMERGENCY HOSPITAL, UNIVERSITY AVE.

In hospital construction each department head should be consulted. The best suggestions from all should be taken into consideration in the planning of these institutions. Another way in which the association may be useful is in calling the attention of superintendents to the necessity of keeping the hospital and its work before the public. In this connection we can take a leaf out of the patent medicine firm's book. They never cease reminding one of their wares.

If you are doing efficient work in your institution, never cease reminding the public of their share in the maintenance of so worthy a charity.

In the May 15th, 1909, number of "The Survey," published by the Charity Organization of the City of New York, appears an article entitled, "Mr. Rockefeller's Greatest Gift," written by William H. Allen, Director Bureau of Municipal Research. The following excerpts are from the article:

"Unnecessary charities are seldom abandoned when once the sympathies of the worthy people, however misinformed, are heartily enlisted.

"Every charitable institution should constantly be making an appeal.

"It is highly important that every charitable institution shall have, at all times, the largest possible number of current contributors.

"Local churches, local hospitals, charities, kindergartens and the like ought not to make appeals outside of the local communities which they serve.

"National and international claims may properly appeal to men of large means, whose wealth demands their doing something more than assist in caring for local charities.

"It is not personal interviews and impassioned appeals, but sound and justifying worth that are attracting and securing the funds of philanthropy.

"Generous and adequate support; management by scientific, efficient and able men; strict accountability of managers, not only for the correct financing of funds, but for the intelligent and effective use of every penny.

"One ought not to investigate a single institution by itself, but always in its relation to all similar institutions in that terri-

tory, so as not to inaugurate new charities in fields already covered, but rather to strengthen and protect those at work.

"If constant appeals are to be successful, the institution is forced to do efficient work and meet real and manifest needs."

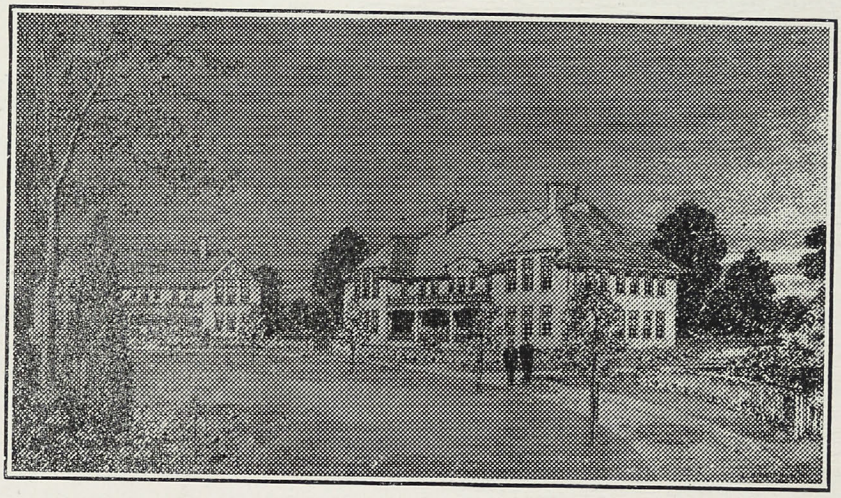
The writer is conscious of having covered much ground already taken up, but is it not necessary for us to be reminded of these things? Each year thousands of infants, children and adults are being sacrificed by diseases which are preventable. I hope some of us may be able to interest the rich men of our province to donate sums of money to institutions for the prevention of disease. It has occurred to the writer that a monthly Hospital Bulletin might be issued from each hospital, dealing with the work done during the month. On the last two or three pages rules for the prevention of diseases might be printed. This would have the twofold effect of bringing the institution before the people as well as being a guide to health. This pamphlet should be sent to everyone in the community. I would suggest that institutions doing this work get increased government grant.

In conclusion I wish to thank those who have contributed in any way to make this meeting a success. Let us remember that there is nothing that succeeds like success. In order that the hospital work may go forward each of us must feel a certain responsibility in trying to do what we can to help the good work of the association. Let us remember we are all working towards the one end—the good of the people.

HOSPITAL FOR THE INSANE, WHITBY, ONT.

THE following is a report on the plans and methods of construction for the new Hospital for the Insane, at Whitby.

The sale of the property on Queen Street, in the City of Toronto, occupied by the Hospital for the Insane, having necessitated the acquisition of other lands on which to erect a new institution, the Department, after a careful examination of sev-



PORTION OF COTTAGE CENTRE
HOSPITAL FOR THE INSANE, WHITBY

eral properties, recommended the purchase of a block of land immediately adjoining the Town of Whitby, in the County of Ontario. This property, which was purchased by the Province in the early part of 1912, is made up of several farms, comprising in all about 640 acres. The soil, which is mainly a clay, is exceedingly fertile. There are about 20 acres of sandy loam, suitable for gardening.

A temporary camp to accommodate about forty patients and

attendants, has been erected, and their labor has been utilized all summer and fall to work the farm.

The main grouping of buildings is placed on a wide, gentle slope, having the advantage of a south-eastern exposure. From this site are extensive open views across Lake Ontario to the south, and Whitby harbor to the east. The town of Whitby lies to the north, and to the west is a prosperous farming country. Great natural beauty, existing trees, orchards and roads, convenient railway and water facilities, all emphasize the suitability of the property for hospital purposes.

The existence of several trees and hedge-lined roads and lanes on the property has had considerable bearing on the general lines of the plan, and the sacrifice of these trees and hedgerows will be avoided, with the exception of a few spruce trees, which can be readily transplanted.

A fine group of trees, serving as the nucleus of a break for south-west winds, will be retained, and should be completed by the addition of sufficient young pine and birch to make an effective shield from the prevailing storms, which are from that direction.

There is a large deposit of gravel and sand on the lake front, which will be utilized in the construction of the buildings, road-making, etc.

Gardens will be laid out around the cottages, providing healthful out-of-door employment for patients, with desirable mental occupation. The garden surroundings and the effect of trees and shrubs, so arranged that no view will show more than one or two cottages, will tend to create a cheerful, homelike atmosphere.

The extended system of cottages and hospitals will necessitate a considerable extent of roadway through the property. While planned on the score of utility, these roads will be laid out as winding drives, so as to permit a park-like development of the immediate site of the main buildings and cottages. The natural slopes of the land will afford good drainage for such drives, and as there is an abundance of gravel suitable for the light traffic to be carried, they can be cheaply and efficiently built. Already the road from the station to the proposed loca-

tion of the Administration Building is such that, with a little labor, a splendid avenue can be created.

The landscape work and roadmaking, together with the scheme for sewage disposal, has been laid out by Mr. W. A. McLean, Provincial Engineer of Highways, and will be executed under his supervision.

The arrangement of buildings outlined on the plan may best be described as an hospital village, where the features that suggest detention will be eliminated, so far as that is practicable.

The plan submitted herewith shows buildings toward the lake front, grouped into three centres, the Hospital centre, and two Cottage centres, for men and women, separated from the Hospital centre by the recreation and athletic grounds.

The buildings when completed will accommodate 1,500 patients, and are so planned that units of 500 each may be added without disarranging the original construction.

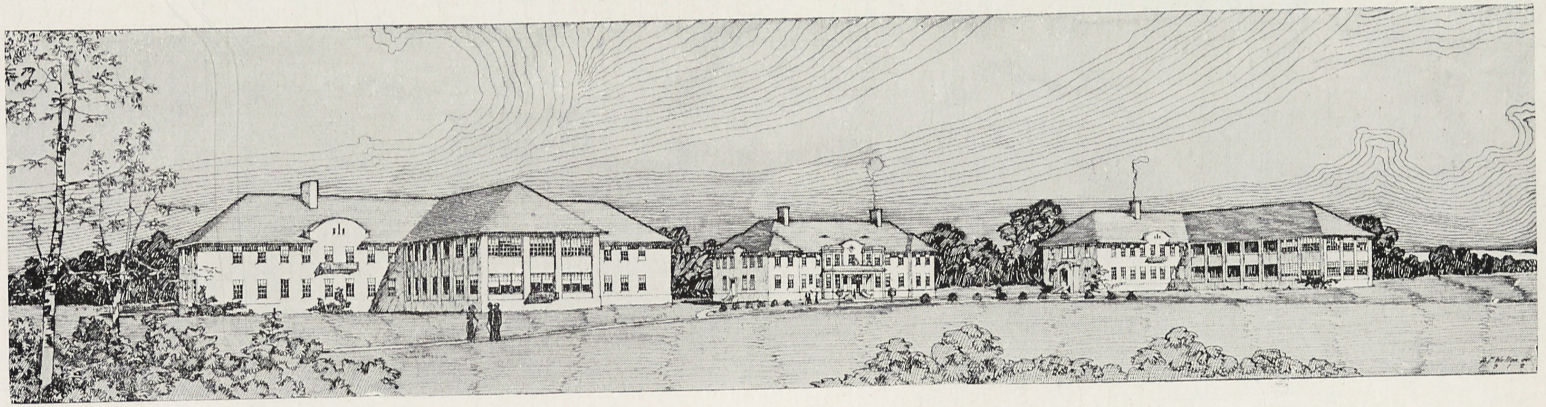
The Hospital centre consists of four hospital buildings, with a central kitchen and dining-rooms. Two of these buildings, accommodating 63 patients each, will be used as admission or observation hospitals, and for incipient cases. With these should be included two convalescent cottages, accommodating 35 patients each. The other two buildings, accommodating 104 patients each, will provide for the acute cases.

The Cottage centres consist of two groups of cottages, accommodating 52 patients in each cottage. For each group an Infirmary is provided, which will take care of all those patients assigned to Cottage centres, and who require special nursing on account of general feebleness or physical illness.

This division of the institution into two distinct sections—Hospitals and Cottages—separates the patients requiring constant medical attention and nursing from the patients requiring only medical supervision of personal hygiene and occupation.

In the Hospital centre will be placed all newly admitted patients; all requiring special attention owing to suicidal tendencies, or for any similar reason, and all requiring ordinary hospital treatment on account of bodily or mental sickness.

The power plant, laundry, etc., are placed away from the residences.



ADMINISTRATION BUILDING AND ADMISSION HOSPITALS
HOSPITAL FOR THE INSANE, WHITBY, ONT.

In this connection, it should be noted that, since the Index Plan submitted herewith was prepared, the laundry has been separated from the other industrial buildings, and (on a revised plan) placed to the south side of the road leading to the Cottage centre. The women's buildings have been changed to the east side of the centre axis line and the men's to the west.

The Cottage centres will accommodate all patients who do not require, or who have ceased to require, for a time at least, special medical treatment, the more easily managed patients, the working patients, and all who would be benefited by the suggestion of normal home life.

The division of the institution into groups permits of more satisfactory classification of the patients, more complete provision in the Hospital section for the medical treatment of those patients who specially require it, and better facilities for making the daily life of the inmates more like that of a sane community.

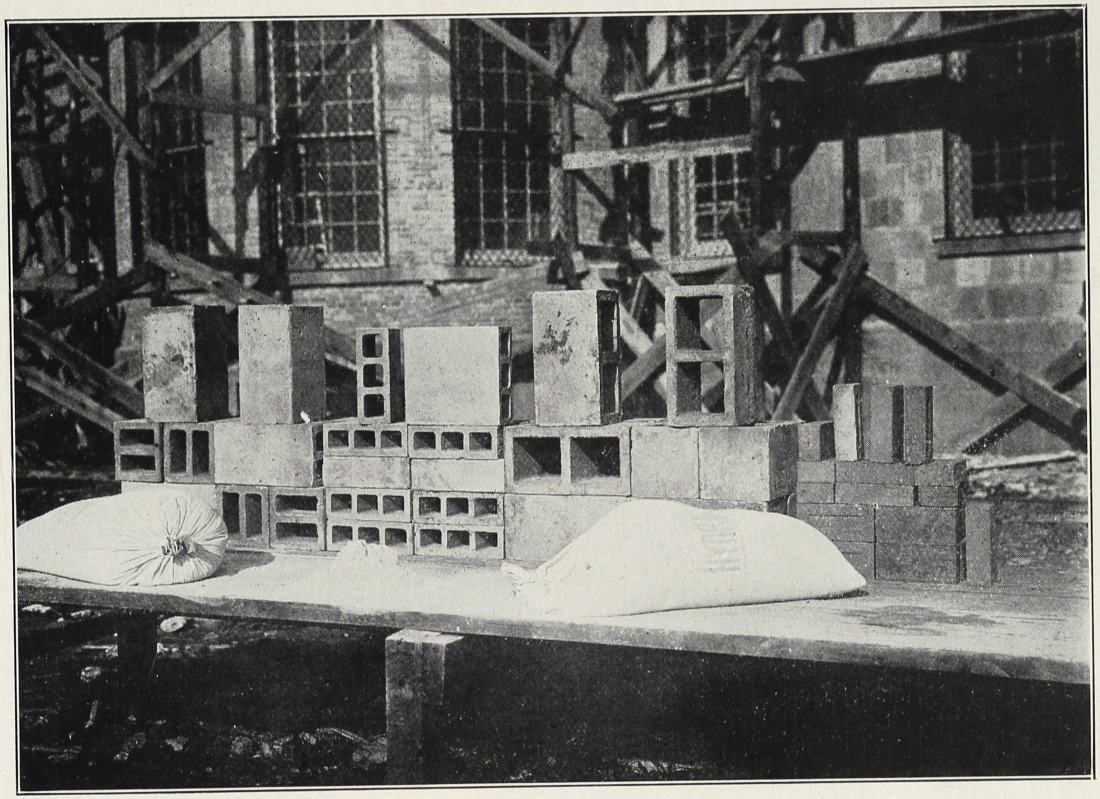
By breaking up the cottage or industrial groups into smaller units, resembling the ordinary dwelling-house rather than an hospital ward, the use of a simpler and less costly type of construction is permitted.

With the proposed classification and grouping, each separate unit can be planned and built with special reference to the requirements of the class of patients it is intended to receive, and by the elimination from this section of all patients requiring exceptional treatment, the administration will be less costly and more efficient.

For each Hospital and Cottage group a central kitchen is provided, with separate dining-rooms attached, in order that the classification of patients arranged in the cottages may still be maintained in the dining-rooms.

The admission or observation hospitals form a separate unit, distinct from the rest of the institution, but in close touch with it. Here patients will be received, cared for and treated; then, if satisfactory progress is made, given a period of probation in the adjoining convalescent cottages, without coming in contact with cases of longer duration in the institution.

The arrangement of the roads and grounds is such that all



BUILDING MATERIALS PRODUCED AT PRISON FARM, GUELPH
FOR THE HOSPITAL FOR THE INSANE, WHITBY

traffic to and from the other parts of the institution need not pass near the admission hospitals.

Special studies have been made, so that in winter every room for patients may have direct sunlight at some period of the day. In summer, sun-purified air can be admitted into a room by means of an open window, but in cold weather this is impracticable, and it is therefore essential to admit the direct rays of the sun.

In all the hospitals and infirmaries very liberal provision has been made for treating patients in sun rooms.

Provision for carrying out the best ideas of psychiatry in the treatment of patients has had careful attention, and the plans embody special arrangements for continuous baths, and other hydro-therapeutic measures, electro-therapy, hot air baths, massage, special rest rooms and hygienic diet, also surgery, dentistry and ophthalmology, etc.

The Acute Hospitals are a very important feature of the institution, and will be fully equipped for medical treatment.

Isolation Hospitals will permit of the proper segregation of all cases of infective tuberculosis and other diseases requiring to be isolated from the general medical hospitals.

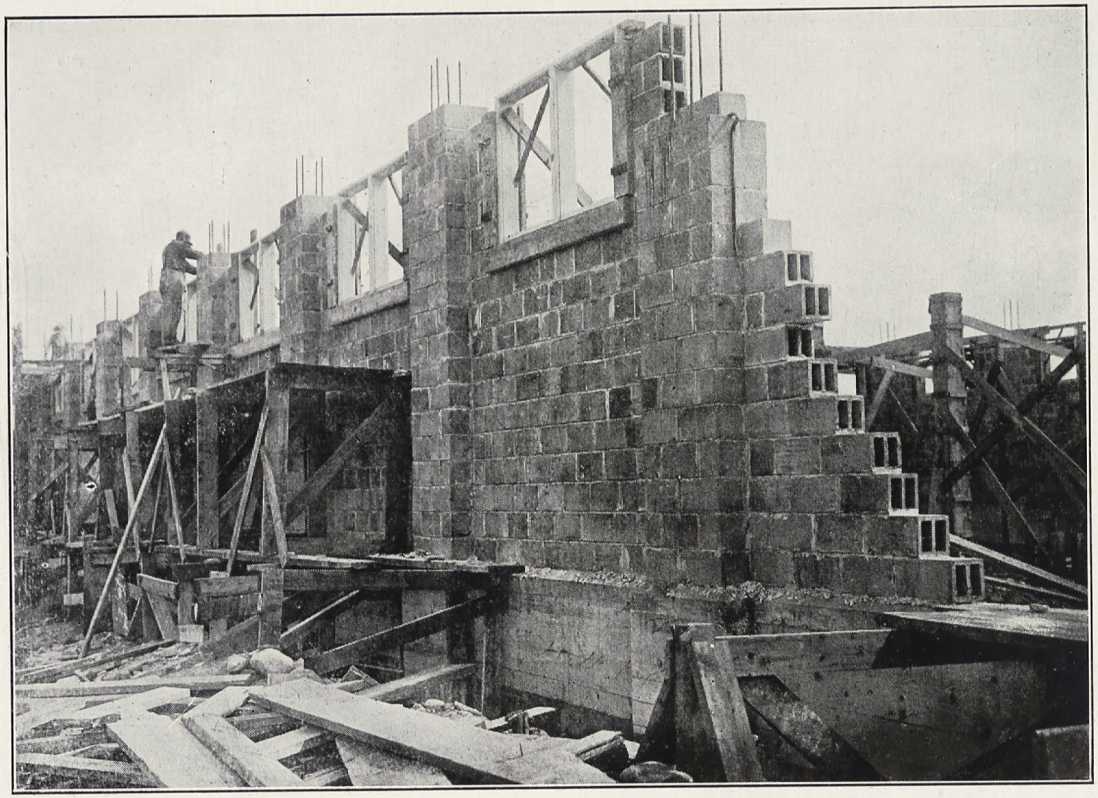
Every facility will be provided for medical research work, both clinical and in laboratories, with lecture rooms for demonstrations and training of the staff.

Officers' quarters and a nurses' home have been so arranged as to be convenient to all hospital and cottage centres.

In order to create interests for the patients and staff, outside of their daily duties, it has been found necessary, in similar institutions, to provide facilities for social intercourse, such as the church, amusement hall for concerts and dances, skating and curling rink, bowling alleys, gymnasium, etc. The proposed location of these buildings is shown in the index plan herewith.

No building for patients will be more than two stories high, and all walls, partitions, floors and ceilings will be fireproof construction throughout.

Careful consideration of the special requirements in the matter of heating and ventilating has resulted in the adoption of a system of "forced circulation" hot water heating, as being the most efficient and economical.



TYPICAL TILE WALL CONSTRUCTION, HOSPITAL FOR THE INSANE, WHITBY

By this system, the temperature of the heating medium can be controlled to suit outside temperature. A considerable saving in operation is thereby effected by decreasing the losses in transmission lines and maintaining lower temperature in the radiators during mild weather, in addition to producing much more comfortable physiological conditions for all who are more or less likely to spend a considerable part of their time indoors.

The water will be heated by exhaust and live steam and circulated by centrifugal pumps in duplicate to ensure continuous service.

It is proposed to depend as much as possible on natural means of ventilation, assisted by an indirect system of supplying pure, warmed air and exhaust ventilation for use in very cold weather, when the natural tendency will be to keep all windows closed.

The plans of the proposed buildings have been prepared under the supervision of Mr. James Govan, architect. His past experience in the design of buildings in which the products of the Central Prison Farm have been largely utilized has given him special qualifications for the work in hand.

Before deciding on the best methods of Sewage Disposal, careful examinations of the subsoil all over the farm were made, to ascertain if an irrigation system to handle the whole sewage output could be adopted. The results of these borings have clearly demonstrated the impracticability of such a scheme.

The system prepared will contain the most reliable features of modern sanitary practice, and the details have been approved of by the Provincial Board of Health.

As there are two drainage levels on the site, it will be necessary to collect the sewage from the lower level in a sedimentation chamber and pump the same to the main disposal plant for treatment in contact beds. For this purpose an automatic electric pump will be installed, with an alternative arrangement whereby the effluent can be pumped on to the land of the farm for irrigation purposes in dry seasons, if required.

The system provides for the convenient removal of sludge; bacterial treatment by rapid filtration through a bed of crushed stone to break up and render inoffensive the organic matter in

the liquid; and finally, chemical treatment to destroy all disease-producing bacteria.

As a result of a test on Concrete Structural Tile, now being made at the University of Toronto, it is confidently expected that a considerable reduction will be effected in the amount of heat required to be supplied to buildings, as compared with similar building construction of different materials.

A test of a section of a new type of reinforced concrete floor is now in progress. In this an attempt has been made to produce a long span floor, avoiding the use of complicated reinforcement, and better suited to the conditions of the work at Whitby.

As far as practicable, all work in connection with the building operations, the installation of the sewage disposal plant, water works, roads, etc., will be carried on by prison labor.

A temporary camp for about 100 prisoners, with guards, and dining-rooms for prisoners, guards, foremen, etc., is now completed; permanent main sewers are being laid and the collecting and treatment tanks and beds for sewage are well under way. The water, electric light and telephone services, and also the spur line from the Grand Trunk Railway, have been brought from Whitby to the centre of the institution, so that the construction of the permanent buildings can be carried on, with every facility for rapid and economical execution of the work.

The results at Guelph leave no room for doubt that the methods adopted there can be applied in the new work, with a positive assurance of greater efficiency and economy than would be obtained under any other system of carrying on the work.

Owing to the very exact system which exists at the Prison Farm of checking itemized costs of material and labor for every kind of work done, thoroughly reliable data have been available in deciding on the most efficient and economical type of construction to be adopted.

The construction and administrative organization will be under the personal direction of Mr. S. A. Armstrong, Assistant Provincial Secretary, who also has charge of the construction of the Central Prison Farm, Guelph.

The foundation walls of the buildings will be of concrete,

but walls and partitions above basement level will be built of concrete structural tile, made at the Central Prison Farm.

In addition to the tiles from Guelph, the wealth of building materials at that institution will make it possible to supply to Whitby hydrated lime for use in mortar, also alca lime for interior plaster, and stucco for outside plastering on walls.

All sash, doors, and other finishing woodwork will be made at the woodworking factory at the Prison Farm.

In conclusion, it may be stated that no effort has been spared to make the proposed Hospital for the Insane one of the most complete of its kind. By utilizing prison labor and taking advantage of the industrial opportunities available at the Prison Farm, coupled with the experience gained in the use of materials produced at the latter institution, the Province of Ontario will have, when it is completed, one of the most modern hospitals for the treatment of mental diseases, both from the standpoint of economy in cost of construction, as well as efficiency of design.

A WELL PLANNED HOSPITAL

BY GORDON C. KEITH.

The citizens of Smith's Falls, Ont., recently erected a public hospital designed by a local architect, Mr. G. T. Martin, and erected by a local builder, Mr. John Davidson. The contract price was $29,000. Later, the public wing was added at a cost of $5,125, and this, with extras, made a total of from $36,000 to $37,000.

The building is located on an elevation in the centre of a four-acre site overlooking the Rideau River and surrounded by a grove of elms. The property was presented to the hospital directors by Mrs. Mary E. Chambers to be a site for a public hospital. The money was raised by the town council and citizens under the direction of Mr. Frank O. Whitcomb, Superintendent of the Frost & Wood Company, Limited, President of the Board of Directors. Mr. Whitcomb has the happy faculty of keeping the foremen and men in the shop "pulling together," and to him is due considerable credit for the enthusiasm and unity of the various organizations interested in the erection of the hospital.

The hospital is an imposing two-story and a half structure, with basement, built of Milton terra-cotta pressed brick, with stone trimmings. It has a frontage of 74 feet and a depth of 137 feet, with a wing 26 by 45 feet, extending to the south. In front is a three-story verandah with Ionic capped columns. In the northwest corner is a small sun parlor in connection with the children's ward, while on the south side is a large two-storey sun parlor. At the south end of the public wing a two-storey verandah has been erected.

FEATURES OF THE GROUND FLOOR.

The entrance to the hospital is through a lobby into an octagonal reception hall, which is shown in Fig. 3. This gives, also, a view of the hall, with the hydraulic elevator in the background.

On the right are the apartments of the Lady Superintendent, consisting of sitting room, bedroom, private bath, etc., while on the left is the office of the Secretary, through which a door leads

to the Board room. It may be judged from the photograph of the reception hall that the hospital is well provided with natural light. In fact this is one of the excellent features of the hospital, which may be seen to advantage in the photograph of the south side.

With the exception of the reception room, all doors and windows are finished with a plain rounded strip. This prevents any dust from accumulating, a thing much desired in a hospital. Floors are oiled hardwood, with possibly the exception of the operating room, to which reference will be made later. The doors and cork matting of the reception hall are green, but white is the prevailing color throughout the rest of the building. The only exception is in the wards, where the doors are finished in the natural color.

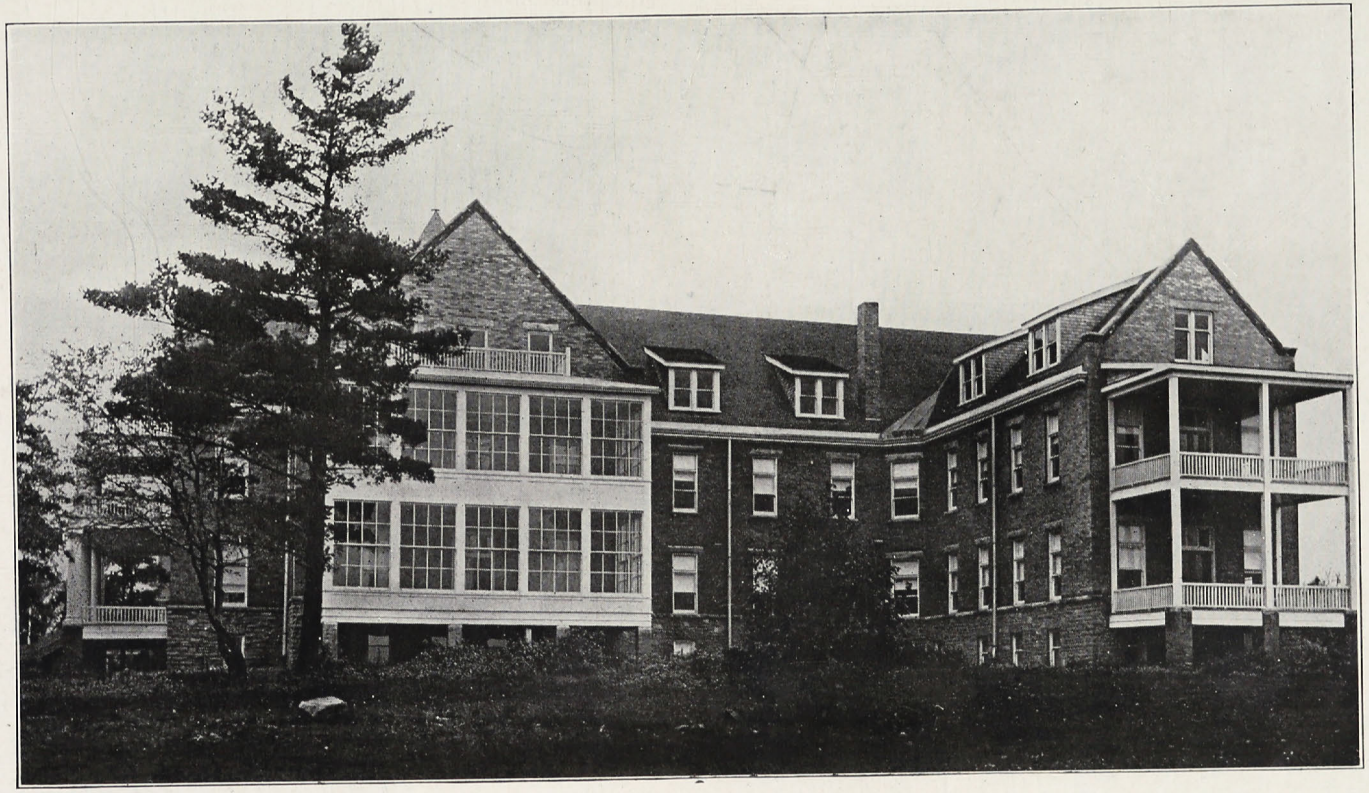
To the east of the Board room and Superintendent's rooms is a cross-corridor. On the north end is a private ward, and on the south end is a semi-private ward used at present as nurses' quarters. Next to this room is a private ward facing the sun parlor. Across the hall is another ward similarly situated.

Following along the main corridor on the south side are linen closets, a private ward with private bath and long-distance telephone, and two other private wards. On the south side, also, is the kitchen, furnished with oil stove, refrigerator and other necessary equipment.

On the north side of the main corridor the arrangement is somewhat different. Beginning from the cross corridor are the quarters of the assistant superintendent; the dispensary; the homelike nurses' sewing room, a view of which is here shown; and the room of the night supervisor.

Another cross-corridor leads on the north to an entrance door opening to the grounds. On the east side of this hall is a private ward. On the south end of the hall is the men's public ward, furnished with nine beds. It has light from three sides and opens out upon a large verandah.

The ceilings on the ground floor and also on the main floor are twelve feet high. Fanlights are provided over all doors to assist ventilation. A complete ventilating system has been provided for and ducts run from the various wards and rooms to the attic, where a slow revolving fan will be installed.



MAIN BUILDING, SMITH'S FALLS HOSPITAL

FIRE PROTECTION AND ELEVATOR.

At each end of the main hall fire hose attached to the town water system are to be found, and on every flat six pails full of water are kept in case of emergency. A fire door, which closes automatically in case of fire, shuts off the main building from the elevator shaft on each flat. Fire escapes have been provided at convenient points in the building.

One of the important pieces of equipment is the hydraulic elevator at the east of the main corridor supplied by the Turnbull Elevator Company, Toronto. When the ambulance drives in at the back of the hospital the stretcher is lifted out upon a platform leading to a double door; as that door is opened the stretcher is carried into the elevator and taken to the main or first floor as the case may demand. The elevator runs by hydraulic power, 100 gallons of water being needed each trip. It is surrounded by a stairway running from the basement to the top of the building.

FIRST FLOOR OF THE HOSPITAL.

Beginning at the front, there is on the right a private ward and on the left the maternity ward. In the northwest corner, reached by the cross-corridor, is the children's department. It holds six cots and children's furniture, opens out upon a small sun parlor, and has a private bath room in connection.

At the south end of the cross-corridor are two semi-private wards opposite each other. Opening out on the sun parlor are two private wards.

On the south side of the main corridor are three private wards and diet kitchen. The women's public ward is in the wing extending to the south. The south side of the first floor is similar in design to the ground floor.

On the north side of the main corridor is a suite of five rooms—anesthetic, operating, sterilizing, doctors' wash-up room and doctors' dressing room. In three of these rooms the floors are of tile, which extends to a distance of eight inches up the walls. The floors are so constructed that they can be washed out by the hose, and the waste is carried away by a drain in the floor. The light in this room is excellent, coming as it does through lights in the ceiling and walls.

KITCHEN, LAUNDRY AND OTHER FEATURES OF THE BASEMENT.

The basement is light and airy, the ceilings being nine feet four inches high. In the northwest corner is a very large storeroom, and on the other side of the hall is the nurses' dining-room. The rooms on the south side of the hall are occupied by the help, including cook, housemaids, caretaker, etc. On the north side of the hall is the kitchen. This is equipped with a two-fire McClary range, splendid cupboards, and everything in the way of kitchen utensils. A dumb waiter runs from the



RECEPTION ROOM, SMITH'S FALLS HOSPITAL

kitchen right to the top of the building. The pantry and ice-chamber are on the east side of the kitchen.

The laundry is equipped with the latest machinery, and is located in the basement of the south wing. The machinery consists of a washer, extractor, mangle, soap tank, etc., of the most approved modern type, operated by an eight horsepower steam boiler, which also supplies steam for the sterilizer.

The building is heated throughout by means of two Safford hot water furnaces, manufactured by the Dominion Radiator

Co. of Toronto. Water for operating room purposes is furnished by a separate boiler and heater situated in the basement.

A feature of the hospital, which will be seen by reference to the plans and photographs, is the number of bathrooms and lavatories. There is also an abundance of linen closets.

In each ward there is a push button connecting with an annunciator on each flat. There is also a system of house telephones, so that the superintendent and nurses may communicate with each other without climbing the stairs.



PRIVATE SITTING ROOM, SMITH'S FALLS HOSPITAL

The attic is not completed, but will be used for nurses' quarters when necessary. The ceilings are high, and this flat will prove very satisfactory for this purpose.

The architect was Mr. G. T. Martin, and the builder, Mr. John Davidson, both of Smith's Falls. The sub-contractors were: Stone and brick work, Adam Johnston; painting, Wm. McKay; plastering, Thomas Manders, all of Smith's Falls; and plumbing, Ross & Co., Brockville.—*The Canadian Builder and Carpenter.*

Society Proceedings

HOSPITAL SECTION
AMERICAN HOSPITAL ASSOCIATION

Wednesday, June 18, 1913.

THE second session opened with a paper by Leonard Felix Fuld, of New York, on "Selection of Hospital Help Under Civil Service Rules."

The underlying principle of the civil service regulations was that the best shall serve the state. The merit system prevents the superintendent from selecting his personal friends, also the appointment of those recommended by acquaintances. Any citizen may apply, and the one who fulfils the requirements best is appointed. The selected party may or may not be efficient, but the best available has been chosen.

The competitive class includes physicians who receive a substantial salary, trained nurses, supervising nurses, stenographers. Open competitive examinations are given in technical questions and experience. The applicant submits written answers to technical questions to test his fitness for the satisfactory performance of the work in the position sought—physician, his knowledge of medicine; nurses, of nursing; stenographers, of stenography. Answers are rated on the competitive scale. In respect to the history of their experience, this is carefully verified and rated in the same way—those who have the best experience receive the highest rate. Thus the best are secured, and the salary is reasonable.

Hospitals pay such small salaries they are unable to secure men and women willing to take examinations. Competitive examinations pre-suppose there are many applicants for the position. If the hospital must search for employees it cannot be expected that they will submit to an examination. The competition is between hospitals and other prospective employers for the employee. So the examination must be non-competitive; the object being to see if the candidate is competent to fulfil the duties of the position, rather than to see if he is the most competent. These are domestics, orderlies, etc. The personal history is inquired into and verified. Such may be destitute convales-

cents. "Rounders" are avoided. This system is a satisfactory means of preventing hospitals from employing, in minor positions, men and women unfit for such.

Next is the laboring class, of which there are two divisions—laborers and mechanics; applicants of both these sub-classes are required to register, and examined in accordance with priority of registration. Each applicant is given a physical examination—mechanics being given a practical test. Then there was the exempt class—those employees not subjected to civil service regulations—internes; but they are given a rigid competitive examination of their technical knowledge and a careful inspection made of their personality.

Undergraduate nurses are likewise exempt from the civil service rules, but must have a certain preliminary qualification required by statute. They are selected by the principal of the training school. Employees in the contagious diseases departments are likewise exempt, on account of the difficulty of getting them. So with the hospital superintendent and the superintendent of nurses, because their administrative duties are so intimately connected with the administrative policy.

In examining applicants by the competitive system, more attention should be given to the experience of the candidates. Personality cannot be made part of a civil service examination, because the introduction of this element would be susceptible of grave abuse. Larger salaries should be given, particularly to the non-professional employee. Poor pay means undesirable employees and unsatisfactory service. Hospitals should furnish maintenance to employees. Such employees have little chance to spend their salaries. Larger salaries would attract a better class of men and women. The bonus plan was commendable—an appreciable sum of money at the end of the term of service, rather than an increase of salary during the service, serves as an inducement to perfection of service and renders lapses less frequent on pay day.

Male orderlies were particularly unsatisfactory in this respect. Satisfactory results had been obtained from employment of army orderlies—they had considerable skill, greater sobriety and were more amenable to discipline.

As to mechanics, particular examination should be made of their fitness—simple tests of mechanical skill.

The hospitals were not doing their duty to the community who graduate only highly skilled nurses. The people of the middle class were not served satisfactorily. There should be two grades of nurses trained—the highly trained nurse and trained attendants, who lack some of the preliminary education of the trained nurse and her higher technical skill. These will serve members of the community who when sick are unable to obtain the services of the higher trained class. The second class can assist the higher class in hospitals and will extend the benefit of trained attendants to those unable or to whom it would be a serious hardship to be obliged to employ trained nurses.

Dr. Collins, of Denver, said the theory of civil service examinations was all right, but would it work out well in practice? It was often difficult to get employees of any kind—in some states. In Denver this was the case, and one could not pay salaries sufficient to certain classes of people to submit to an examination.

Hospitals are built for the poor, and for the rich, but the people of moderate circumstances cannot find hospital accommodation. A large New York corporation had to advance $1,157 to meet the expenses of a clerk of theirs in very moderate circumstances—for two months' hospital treatment. This included the surgeon's fee and nurses at $50 per week each—day and night. How could such a man pay nurses a salary of $50 a week? He would be better were he a pauper. The largest and best class of the community must say they are paupers or they cannot get accommodation at all. If hospital treatment is the proper thing—and we all believe it is—some radical steps ought to be taken to make provision for this class of people in our hospitals, and the charges against them should be proportionate to their ability to pay. Something must be done, sooner or later.

The speaker did not agree with the reader of the paper that we should turn out a lot of half-trained nurses to take care of the best class of people in the community, and give paupers the best we have got. That was mighty poor reasoning and entirely wrong. This great class were the foundation of the community,

who really earned most of the money which has been used to build hospitals, who pay most of the taxes. They are the ones who should be considered.

Dr. Joseph Howland said the possibility of a bonus never appealed to him. It was an unmerited thing. As an example of how it did not work, there had recently been a strike of several thousand telephone operators. In the terms of settlement a bonus was suggested to the operators. Dr. Howland was glad that the operators turned the proposal down good and hard. He thought the attempts of employers to hold employees for a period by a reward at the end of that time was wrong. They either earned it or they did not. They did not by simply hanging along on their job to the end of the year. Pay should be on the basis of what is earned in going along.

Dr. Collins said he had tried the method of trying to hold internes and employees by paying a lump sum at the end of a certain term of service. It did not prove satisfactory. They wanted their money every month. Since then he had no trouble.

Dr. John N. E. Brown said that employees should be well housed, well fed, well paid, kindly treated; and, if possible, the hospital should endeavor to make provision for old age of those who served a long period of years. The securing of married employees in certain positions made for stability and efficiency.

Dr. John A. Hornsby had tried the plan of paying from $2 to $5 per month more to his employees than did the other hospitals, in order to get the best. But he did not get any the best of it. Something else was wrong. He fixed up the old nurses' home for the female help, the superintendent of nurses and the housekeeper joining enthusiastically in his efforts to betterment. Two reception rooms were fitted up with nice furnishings. In about a week it was reported to him that these employees had been dancing on the top of the new table and on the top of the piano, and had scarred the latter with the nails in their shoe heels. His dreams went to pieces. He had never been able to do anything to the employees except pay them wages. He had never had the same wages in the same house for the same class of employees at the same time. He had had one orderly at $25 per month performing the same service as another to whom he paid $60. The latter had served for years—knew the whole

technique of the institution, and would do four times the work the cheaper man would do and do it four times better. It was explained to the latter that it was a fair deal; that he would get $60 per month when he earned it.

As to the orderlies from the army, Dr. Hornsby had not good luck with them. He had tried such a man as head janitor, but found him a periodic drinker and was forced to let him go.

Miss Hartry, of Minneapolis, had tried the plan of increasing the wages of the employees who remained one year. Two weeks' vacation were also given. One floor maid was still with them. She gets an increase every year. A floor man had remained two years. He was increased $5. Said he would never go away now. A home was provided for female employees outside the hospital, but on the grounds.

As to the nursing, a trial had been made by the speaker of nurses partially trained, but it was a difficult proposition. The object seemed to be to supply to the man of small means nurses who have had some hospital training at $10 or $15 a week. In Minneapolis there were many half-trained nurses, who have been in a hospital from three months to a year. They either leave, thinking themselves competent to nurse or are sent away. Most of them begin to nurse right away. There was no serious objection to their doing that, but there was strong objection to doctors picking these half-trained nurses up and giving them employment at $25 per week. Physicians were employing some of these nurses who were expelled from the training school for cause. Miss Hartry did not know of any of these nurses working for $10 per week. If the middle class was to be helped in this way the hearty co-operation of the medical profession was required to keep these half-trained nurses in their places.

Dr. H. B. Howard said that the civil service rules presupposed that there were a great many people who lack positions. If a hospital had a long waiting list, the civil service rules were all right to apply. If you have not a long waiting list, these examinations would hamper you terribly in filling your positions. He had tried it. In most any community there were plenty of people to fill positions, if a superintendent developed the thing sufficiently, so that they really know what the positions are which are to be filled, and have a clear idea in regard to

them. You were sure to keep people in these positions if you studied your people and knew actually they were filling the bill. There were all sorts of ways of filling a position. Some do it so well that they wear themselves out. If you treat that person who is really doing the work so well on the same basis as the one whom you have to spur on to do his work, you lose them in the end. If your hospital is small you must know your individuals and treat them according to their deserts. The levelling of employees down and treating them all according to an absolute rule had a tendency to make it harder and harder to get positions filled.

Dr. Rupert Norton, Assistant Superintendent, Johns Hopkins Hospital, Baltimore, read a paper on Municipal Hospitals and Their Relation to the Community. Municipal hospitals were a disgrace and did not serve the purpose they might. The exceptions could be counted on one's fingers. Exceptions were the Boston City Hospital and the Cook County Hospital, Chicago; the New Bellevue, New York. The new city hospital, Cincinnati, promised to be an excellent institution.

The municipal hospitals in Germany are the best in the world. Many of the smaller towns have good hospitals. Mention was made of the hospitals at Berlin, Hamburg, Dusseldorf and Cologne. Why the difference in America? German hospitals are built and managed by men of experience. A careful examination is made of the site, and the greatest care is exercised in drawing the plans. The task is performed by an expert.

The association with a medical school was beneficial, because the physicians in turn make up the staff. The hospital appointments are free from the evil influences of political parties. The German hospitals are show places, like the schools, courthouses, city hall and other municipal institutions. In this country we would divert a stranger from seeing our municipal hospitals. How could America remedy her defects and deficiencies and take an equal rank with Germany?

One of our national traits was our indifference to life. Thousands of lives were being yearly needlessly lost by death or wasted by illness. We improved, but how slowly! Our hospitals were poorly constructed and worse administered, and we

had often failed to build hospitals where needed. Our indifference accounted for the pollution of our drinking water and the presence of typhoid. When we built hospitals, incompetent men were selected, who knew nothing about modern hospitals; and who did not take trouble to inform themselves—chosen for their political influence rather than for any knowledge they had of hospital construction. The Cincinnati hospital was an exception. Everyone knew the years of study given by Dr. Christian Holmes in working out the plans. From now on models of construction were available. It was unfortunate that the system of political spoils interfered in every way with such undertakings. With money wasted or stolen by dishonest contractors, the community does not get what it ought to have. The hospital having been built, it is put in charge of someone who knows nothing of his duties—his position secured by pull or because he was the henchman of some politician. It was impossible thus to secure the services of the best physicians. The term of service was insecure. The selection did not ensure the confidence of the public. The general result was that our municipal hospitals were discredited.

What could be done to improve conditions? It was not a difficult task. Our communities were waking up. Education was what was needed. It was surprising that our people who had led easy and successful lives had paid so little attention to physical ills and discomforts. Conditions were changing. Living was not so easy.

It was the duty of a community to prevent disease and to cure the sick. To do the first, one of the main essentials was to provide pure drinking water. To accomplish the second, one or more hospitals should be provided. A general hospital was necessary, provision being made for children, contagious cases (including venereal), a pavilion for tuberculosis and one for insane. There should be a convalescent home not far outside of the city, so that the sick might be looked after in the best possible way. Too much care could not be given. Health means wealth. A community can well afford to spend large sums to prevent illness—sums which are insignificant compared with the endless cost of caring for the sick. The better the health of a community the less need of many hospitals. Hospitals should

be attractive to visitors and to patients. Hospitals should be made to fulfil their ends. The better the health of a community the less need of hospitals. Too little attention had been paid to certain features in the construction of municipal hospitals—notably the kitchen, utility rooms, etc. Elevators and toilets were often too small and poorly ventilated. Proper kitchen, laundry and dining-room accommodation spell economy of administration. Nurses should be well looked after, given airy rooms. Without attention to these matters it was impossible to secure a first-class institution. We should disinfect the waste water from hospitals, as the Germans do, when there is danger of contaminating drinking water by not doing so.

Municipal hospitals will increase in number, because private hospitals are too expensive to be founded or supported. They should not rank below the private hospital in attractiveness and value. There was no reason why the classes should not receive treatment in the municipal hospital—the middle class and the poor. To-day the rich received the worst accommodation.

The prime essential for the good conduct of a municipal hospital was to see that everybody was trained to fill the positions they hold. Their terms of office should be secure and permanent, so long as they remained competent and honest. The best superintendent possible should be obtained, whether lay or professional, and paid a liberal salary—$5,000 to $10,000 per year. He should be especially trained for the position, and retained during good behavior, so long as he is efficient.

A trustee board of eight members was recommended. Too large boards did not work well; if too small they would not have the requisite judgment. Trustees should be laymen, but one physician might be a member of the board. Trustees should be chosen from among the leading citizens—men who handle big businesses—elected for eight years; two eliminated each two years, and not eligible for election until two years have elapsed. Thus the development of cliques was prevented. The board should be free from all political influence. They should not interfere with the superintendent. The superintendent should authorize all purchases and supervise all expenditures. He should select his assistants, the superintendent of nurses, and other heads.

He was responsible to the board, and they, in turn, to the community. In a commission form of government the administration would be different, but the superintendent ought to be appointed for his ability, not for political reasons.

The appointment to many positions was best under civil service rules; but not those of superintendent, superintendent of nurses or medical staff. Orderlies and other help were best protected by being under the civil service rules; thus escaping unjust dismissal. No civil service examination would test honesty and executive ability.

The board should elect the medical staff, and should constitute, with the superintendent, the medical board, and through the superintendent transmit recommendations to the board. The medical board looks after the patients, but has nothing to do with the business administration. The medical staff should receive suitable remuneration.

Private hospitals will become fewer and university hospitals increase in number. The deficiencies in hospitals are due to the medical profession. The best physicians have not shown any interest in hospitals or attempted to make them better—due to indifference and a desire to make money. Interest was increasing. Time was wasted in discussing trivialities. Some doctors were afraid to speak out for fear of losing their practices. If the profession would get together and demand what was right and necessary, they would have the people behind them for needed reforms. Physicians had been slower than laymen and laywomen in inaugurating social reforms. They had the ability, why should they not lead? The relation of the municipal hospital to the community was a most important matter and required deep study by all.

AMERICAN HOSPITAL ASSOCIATION

WEDNESDAY, AUGUST 27—MORNING SESSION.

SMALL HOSPITALS' SECTION.

THE meeting was called to order at 10 a.m. in the Copley-Plaza Hotel, the Secretary, Dr. J. N. E. Brown, presiding.

Mr. G. W. Olson, Superintendent of the Swedish Hospital, Minneapolis, read a paper on "How the Smaller Hospital May Be Made Self-Supporting." A summary of this appeared in our September number.

DR. COOK, NATICK, MASS.: "I have just two points I want to make now. One is the remedy, that we are indebted to President Roosevelt for. We may not all throw up our hats to-day for Roosevelt, nevertheless I think he gave us a most excellent solution of many questions, and that is publicity. I believe one great need in the securing of the support for small hospitals in smaller cities and towns is publicity. Make the public understand that it costs to run a hospital, get the public to understand that everything has to be paid for in a hospital, give them to understand that they are getting better care at lower rates than they can possibly get at home. They do not know that. Why, our hospital was opened in March, 1899, and yet I am surprised at the ignorance of many of the people of that town in regard to the financial situation of the hospital, and it represents simply all hospitals. They do not know that ward patients are receiving gratuitous service from physicians and surgeons. They suppose, many of them, that the physicians and surgeons are paid for the care of the ward patients. They ought to know that they are not. It is not a year since I had to tell an old-time resident of our town that those on the staff received nothing.

It may be of interest to know that a little account was kept for several years of the services at the rates that we received in Natick—and they are small rates—in dollars and cents, and perhaps I can best illustrate it in this way. We have a district nurse association that was started almost the same month that our hospital was opened for service. One of my patients, one of the old residents of Natick, said to me one day: "Dr. Cook, I am raising some money for the District Nurses' Association; I thought perhaps you would like to contribute something."

I said: "Deacon Wilson, the District Nurses' Association is a most excellent organization and doing most excellent work, but the physicians connected with our hospital are every one of them giving more to the poor patients than you will get in money from any layman. Do you think we ought to give money?" Then I made a computation, and, without going into the detail of it, I will tell you how it came out. Twelve Boston and Natick physicians and surgeons—I am including the Boston consulting surgeons—had given in gratuitous services at ward rates, that if they had collected money at the Natick rates for surgical operations and medical service for the number of years that it had been open, then about six years, if they had been paid for that and had given that money to the District Nurses' Association, they would have been no poorer than they were then, but that District Nurses' Association would have received money enough to have paid its bills at $900 a year for 25 years. That was the service that had been given by the physicians and surgeons. Now, they ought to know that. You say that is a plea on behalf of the physicians and surgeons. No, it is not, but it is putting before them what the community is receiving. Then another thing. Many a patient is receiving for $20 or $25 a week, others for $15 a week, what that same patient and the same nursing service simply, and care rendered that patient at home would cost the patient $50 to $75 a week, and yet they complain of hospital charges because they are so high, and when I have put those facts before them they have seen it in a new light.

The speaker alluded to the man who went down to Jericho and fell among thieves, and the kind friend who took him to an inn and told the inn-keeper to keep account of what he expended and "when I come again I will pay thee." That is all right, good friends, if that was a poor man, but I have wondered a good many times whether the person who received those services, although he was robbed then and there of all he had, had a bank account large enough so that in the end he could have paid for those services, and whether he ever did or not.

Mr. G. Fowler, Supt. Vassar Bros. Hospital, Poughkeepsie: There are a number of Vassar philanthropies in Poughkeepsie, all of which are attributed to Vassar College. This is an entirely distinct and separate institution.

I want to emphasize one point which the reader brought out, that the hospital should be a medium for philanthropic effort. The institution which I represent has the fortune, or misfortune, to be very largely endowed, so that the people of Poughkeepsie have had no reason to participate in contributions to the carrying on of the work of the hospital, and I have been impressed very forcibly with the fact that it has paralyzed every bit of philanthropic effort in that community. I was once talking with an eminent doctor in New York. I asked him what proportion of the moneys which carried on his institution were derived from the income on the endowment, or investments. He said, "Twelve thousand dollars, and our institution spends $400,000 to carry on its work, and we wish we had not the twelve thousand; it is a stumbling block in the way of any philanthropy." It seems to me that is a point well worth enlarging upon and emphasizing, that the hospital affords a medium through which the philanthropic people in the community exercise their philanthropy, and the essential thing is to arouse by publicity and in every way possible the need of the function of the Good Samaritan, that the individual still has some work to do in caring for the sick, and the hospital is a modern means or medium by which that work can be more effectively carried on.

CHAIRMAN: Are there not some others who would ask some questions or take some further part in the discussion? The paper was bristling with points. You may have observed that Mr. Olson takes a different view with respect to the medical organization of the small hospital than was taken yesterday by the reader of one of the papers, in that he recommends the open hospital. I should like about twenty experiences from members present here as to how they are getting on with open hospitals, or how they are getting on with closed hospitals. We in the larger hospitals, especially those that are city hospitals, advocate the policy of a strictly closed hospital, while I believe in country places and smaller hospitals that is almost an impracticable thing to be carried out, and I should like very much to hear, and I think the rest of you would, some of your experiences on that point which Mr. Olson has raised.

MISS NETTIE B. JORDAN, AURORA, ILL.: I am from Illinois and I want to say that the medical men of Chicago and some

of the leaders in the State Medical Society undertook to have a closed surgical clique, in order that we would have staffs, simply a staff in each hospital that would do the operating, and they presented this to the State Medical Society and it fell flat. They undertook to put it through the State Legislature at a time when I was there, and it also fell flat there. I think in the small hospitals that we must conduct them on open lines to all reputable physicians. Of course they may in large hospitals be able to find it to the advantage of the hospitals to have them closed, but they cannot do it in small hospitals. I represent a small hospital with thirty beds, and with three other hospitals in the city that give us a competition that is keen, I am sure that we could not afford to have a closed staff, and most superintendents of small hospitals will testify that the work done by these men in smaller communities is creditable to any hospital. It was tried in Illinois to establish the practice of closed hospitals, so that we would have to send all surgical cases to Chicago, or some other hospital in larger cities, but it did not pan out.

CHAIRMAN: The question on this open hospital, of how you raise money, or how you fail to raise it, is a very vital question with all of us.

MISS JORDAN: If I may be pardoned for speaking again, I think I made a record last year on finances. In our hospital last spring we were running short on our finances for the maintenance of our hospital, and our hospital board came to me and wanted me to explain why we would have a deficit there, and I explained to them that we had more wards than private rooms, and even though I was collecting 95 per cent. of all earnings, yet I was not able to make ends meet, so we put on a tag day—you all know what that means—and we were able to clear $5,000 in one day above all expenses, so it was worth the trouble, and we were then able to carry our deficit over a number of years. It was done by the aid of a great deal of publicity, and—the way I express myself—I get on the ground floor with all the newspapers, and for two years I kept up a constant plea for new buildings, that the city needed a better hospital, kept this continuously before the public for two years, then we put on this publicity campaign, Mr. Bowen conducting it, and we were able to receive pledges to the amount of $16,000. There were 14,000

people that give to the hospital; that means that we have 14,000 people that are interested in this hospital. Everyone is saying to me, "When is our hospital going to be built?" That means that they are interested in that hospital, and though we have not an endowment, yet we have 14,000 people interested in the affairs of the hospital and anxious that we should stand at the top notch in the community in equipment and support of our hospital.

CHAIRMAN: Some more life stories, please.

DR. COOK: In Massachusetts the laws are such that, to hospitals owned or controlled by cities or towns, the cities can make an appropriation each year. There has been also a hospital founded by something like $150,000 given to the town in its corporate capacity by trustees chosen by the town, one each year for seven years, and they have full control of the hospital. The town can vote nothing in the way of regulation, that is, it can vote all it pleases, but cannot control, and when it has chosen its trustees its authority ends. Our chairman is a well-posted lawyer; he has looked up the laws very carefully. We had difficulties, although we han an income from $100,000 from funds for buildings, we let the fund accumulate and we erected our buildings substantially from the income and left the original sum. Nevertheless, we had to resort to various means which you all know about in your own experience, until our chairman, a lawyer, looking up the laws carefully, found that the town could vote an appropriation each year, and so for the last few years we have had an annual appropriation of $3,000 voted by the town, raised by taxation, and we have had no deficit since. That appropriation will have to be raised in the coming year, but that has been the solution for us. You say that does not arouse the same philanthropic spirit; perhaps not, but it does this, it makes people of means contribute who would not otherwise give us one cent. They are taxed for it, and they all contribute in our town now according to their tax list. That has been our solution, and other Massachusetts towns, I suspect, will do the same thing. I do not know how it will be in other States.

CHAIRMAN: Let us hear how it is in other States.

Miss Jordan: We have a similar law in Illinois. I have been investigating this law and find that there is a possibility of this appropriation being cut off any year—the politicians can cut this appropriation off any year, and that takes away the definite income. I wonder if that is true in Massachusetts?

Dr. Cook: That can be done any year, but what would be the result? It would hit the poor people; it would hit the people who are now receiving ward care for nothing. Just as soon as any hospital cannot pay its bills it must contract on its charity work, and I doubt if you can get any town to cut off the appropriation for any length of time, when they understand that they are hitting the poor people, not the people who can pay their bills.

Dr. Wheeler, Worcester: There seems to be a little difference of opinion between Mr. Olson and Dr. Cook. Dr. Cook pleads for an appropriation from the town, and Mr. Olson thinks that a hospital supported by taxation should not receive pay patients. I quite sympathize with that idea. I think that the tax-supported hospital had better not look for support from private patients; I think things will be straighter and healthier with those two things separated, and whether Dr. Cook's plan of having an appropriation from the town or city is not even more enervating than a fund, an endowment for the hospital, I should think, is a question. I represent an endowed hospital, so perhaps I am prejudiced, but it seems to me that a board of trustees that cannot manage an endowment and get over that difficulty is not clever. I think that an endowment is just as proper a form of support as a hospital can possibly have, and that somehow the board of trustees ought to make that appear right to the community.

In addition to that I just want to express my pleasure in the paper of Mr. Olson's. It seems to me healthy all through. There is no flaw in hospital management when you get it on a business basis, so that you get out of it what selfishly and humanly and properly should come out of it. Then all your charity beyond that is all right, but have the thing founded on a business basis and not built for charity alone. I think that makes the thing more healthful.

MR. PALMER, FRAMINGHAM: I want to congratulate the reader of the morning on his very excellent paper, and I want a copy of his last report. I want to make two points. The first is that I think that a big endowment in small communities is not necessarily a blessing. I represent a hospital that has been running over twenty years with 75 beds, and we started with nothing. We are not like the poor man who said he was born with nothing and he had the same when he died. After twenty years we have a building paid for, and we have the goodwill, or ought to have the perfect goodwill of the community in support of it. A big endowment leads the people to say, "You have got an endowment, pay your bills." If the hospital is poor, the people are very apt to say, "It is our hospital," and they will go into their pockets on proper occasions and dig out the money to help carry it along.

The other point I want to make on Dr. Olson's paper is, I rejoice to hear him say that he has an open hospital. I have very strong and positive feelings on that question. Our hospital had a wonderful success, and I believe it was chiefly due to the fact that it was an open hospital and every physician was welcome to bring his patients and take care of them in the wards and in the private rooms. While the closed hospital and a clique, so termed here, may be the true and best policy for city and large hospitals, my experience and observation and conclusions from the thirty years I have been connected with a so-called small hospital is that the open hospital is the thing for the small hospital and that every doctor can feel free to take his patients and have the same care of them that he does in their home.

MISS HARTRY: I have been waiting for a number of years to hear just such a paper as we had this morning from my friend and neighbor, Mr. Olson, of Minneapolis. Each year, when attending the convention, and, being an Eastern woman, knowing something about the Eastern closed hospitals, I have had several discussions with members of this Association, who have asked me something about open hospitals, and it has seemed to some that an open hospital would be quite an impossible situation. The last speaker spoke of rejoicing to think that he had an open hospital. Sometimes we rejoice, those of us who are in

open hospitals, and sometimes we do not. However, I want to say that the hospitals in the Middle West were organized in this way, and are operated as the hospitals of Minneapolis, the Swedish Hospital we have heard about this morning. Forty-two years ago St. Barnabas Hospital in Minneapolis was organized, when the city was quite an infant. It has operated ever since and has been called an open hospital; that does not mean, however, that these hospitals do not have a staff. The majority of them, I think I may say all of them, have. For a number of years the men composing the staff of these open hospitals have been trying to close down, have been trying to shut out, certain physicians, young physicians, I may say, and a little over a year ago we found ourselves in rather a peculiar situation. We had either to enlarge our staff and take in so many men that the staff would not mean anything, or we had to have an open hospital in reality. The board of trustees were unwilling to try such an experiment, and so they devised a scheme like this; they thought they would appoint three members of the board and three physicians and the superintendent, who would compose a committee of seven, and to that committee should be given over the management of the hospital. This committee was appointed, but I think perhaps I may say it this morning, because you are in the minority, we could not seem to find three doctors who agreed on just the management, so that that idea was abandoned, and after considering the matter and holding numerous meetings, we decided to have an open hospital in reality, and so we have not had a staff since June of this year. We have been operating quite successfully without a staff. I do not know that there is anything else to say.

CHAIRMAN: One question. What is it that made you mourn, Miss Hartry?

MISS HARTRY: It is too long a story.

CHAIRMAN: Tell it please.

MISS HARTRY: In a closed hospital there are four or five men to please, and sometimes it is a little hard to please four or five. In an open hospital there are 45 or 55, as the case may be, and it is a little harder to please the 45 or the 55. At the same time I never quite could understand why any hospital, espe-

cially a hospital not operating for profit, not endowed, not receiving any government or city aid, why that hospital should operate for five or six men. Why these five or six men should, at no cost to themselves, ask any hospital to open a workshop for them where they could, as Mr. Olson says, in a morning make anywhere from $500 to $1,000, go away, leaving us the patient to care for and the burden of the financial expenses.

CHAIRMAN: Thank you.

DR. NOYES, COLUMBIA: I want to say to the last speaker that she need have no fear of the success of her plan of an open hospital. We have had an open hospital for five years; we have no staff at all; we have absolutely no difficulty in pleasing men; we find it is far less difficult to please practitioners in a small general hospital when they come absolutely on the same basis, obligated to no one man more than another, and we have absolutely no difficulty in obtaining free service and attention in the most generous manner from any practitioner from whom we ask it for any indigent patient.

MISS ELIZA SURBRAY, WARREN: We opened a small hospital in 1907. There were fifteen doctors in the town of 15,000 inhabitants. The community was very much opposed to the hospital being built at all; said they did not need it. In order to have the doctors all send us their patients we had to put the fifteen doctors on the staff and divide up the staff so that we would have two and three on a month. Fortunately we did not have many charity cases, so it was not difficult to take care of the charity work. The hospital was built for 25 beds, but we have 35 crowded in, and we get along very nicely with the staff and open hospital. When we have a charity case come in, we call the doctor that is on duty that month, and if it is a surgical case he calls the surgeon, whomever he prefers. We have gotten along very nicely that way, and I might say that our hospital is self-supporting. When we opened in 1907 we had a debt of $10,000, and we have cleared that off and we are practically self-supporting, no endowment whatever.

DR. FOWLER: I should like to ask some of these gentlemen who have had experience with an open hospital what the effect is on the nurses' training school, if that is carried on. It seems

to me that one important thing is, to have some sort of organization and system of regularity, and if there are twenty doctors coming in with patients, each doctor has a different mode of treatment, a different way of doing things, it might perhaps demoralize the nursing corps.

(*To be continued in our next number.*)

Hospital Intelligence

CANADA

Winnipeg Hospitals

An agitation is on foot for a new General Hospital in Winnipeg, to be situated in the north end of the city. The present Winnipeg General Hospital is a voluntary hospital. The city has contributed $630,000 towards its construction, and has now seven aldermen on the board. Its capacity now is: Public ward beds, 234; semi-private, 166; private, 58. Total 458. The trustees are appealing to the city for $275,000 more.

The Toronto General

Mr. Conrad Thies, Secretary of the British Hospitals' Association, paid a visit to the Toronto General Hospital. He noted certain architectural defects.

"The passages and corridors are so constructed," he said, "that it is necessary to rely on artificial light to illuminate them, even on the brightest days. This is a serious mistake."

Mr. Thies expressed the view that there was a mistaken policy general in Canada in adding to old and building new hospitals in the central districts of cities. "I feel that it would have been better," he said, "if the new hospital here, instead of being located in what is practically the centre of Toronto now, where the cost of land was high and future enlargement a practical impossibility, had been built a few miles further north, on higher ground."

Winnipeg Civic Hospital

The first report of the Winnipeg Civic Hospital Commission has been handed in to the controllers and adopted without special comment, as it was entirely satisfactory. The new King Edward Tuberculosis Memorial Hospital, opened July 26, 1912, with a capacity of 72 beds, costing $119,000, had treated 129 cases of advanced tuberculosis. The new King George Hospital for infectious diseases will be ready to open about the beginning of next year. A greenhouse has been erected and also a power house and laundry. On July 11, 1912, the hospital was visited by T. R. H. the Duke of Connaught and the Princess Patricia. $10,000 will be appropriated for a residence for the medical superintendent.

New Wing for the Regina General

A new wing will be added to the Regina General Hospital, and also an isolation hospital. Dr. Dakin, one of the members of the staff, has spent several weeks in visiting the hospitals of the Dominion, getting pointers. The anticipated cost of both buildings is $225,000.

Montreal General Hospital

A new and up-to-date out-door department has been built at the Montreal General Hospital, called the Charles Alexander Memorial Out-Patient Department. A reorganization of the medical staff has been under consideration.

In Saskatoon

One of the latest Saskatoon hospitals was opened on Sept. 18th, with much social eclat. This is a private institution directed by Mr. M. W. Hoffman.

Toronto Again

It is likely that the city will give Toronto east end a valuable hospital. The East End Hospital Association have approached the City Council in the matter. The proposed site is east of the Don and south of Danforth.

For Injured Employees

The Dominion Iron & Steel Co. are about to erect a new modern hospital at their works for the exclusive use of their employees. The new building will be of brick and will be built on the site of the old general office which was destroyed by fire some time ago. It will be modern in every respect, and will be equipped with all the latest appliances. Work on the structure will be started at an early date.

For Sick Babies

The corner stone of the new St. Justine Hospital for Sick Babies, Montreal, was opened in October. This hospital has been in existence for a year and has outgrown its present accommodation. The new building will be completed by May 1st.

In Summerland, B.C.

There is just beginning to be heard in Summerland hints of an effort to acquire a site to build thereon a more suitable hospital than the little house which at present receives patients. A few who are interested are endeavoring to get together materials, etc., that will permit the holding of a bazaar and tea, some time in December, in aid of a fund which will be needed to secure suitable premises.

A Generous Offer

Newcastle is to have a public hospital if present plans do not miscarry. A person, not named by Mr. McCurdy, has offered $25,000 to build and equip a hospital here on condition that the means of maintenance is found elsewhere. $5,000 endowment has been promised by one citizen. The citizens will probably vote $500 per year for the same purpose.

A New Wing

The new wings of the Winnipeg General Hospital, which cost, exclusive of furnishing and equipment, $650,000, were opened recently by Mayor Deacon. The addition brings the accommodation of the institution to 478 beds.

New Nurses' Home

The new Nurses' Home of the Brantford General Hospital has been opened. Dr. Bruce Smith gave an address at the opening on hospital work.

British Columbia

A new hospital, built and owned by Dr. Henderson, has been opened at Powell River. The hospital just erected by Dr. Henderson is a handsome two-storey building, occupying an elevation overlooking the beautiful village and harbor of Powell River. It is capable of accommodating twenty-five patients without overcrowding.

Grey Nun's Hospital

This new Saskatoon structure opened in October. The structure is of dark red brick and viewed outwardly has a most substantial and imposing appearance. Ward accommodation is sufficient for one hundred patients. In addition there is excellent equipment for surgical operations.

Kingston General

The new wing at the general hospital, which has cost almost $40,000, is nearing completion and should be occupied by the first of the New Year. It is ideal in every respect.

Alterations to the new city hospital, Hamilton, will cost $100,000.

A new General Hospital is proposed for the eastern part of Toronto. Dr. C. J. Hastings, M.H.O., Toronto, has been asked to report on the need of such an institution.

An additional hospital building is being built at the Glace Bay General Hospital.

A new fireproof addition has been made to the Nicholl's Hospital, Peterborough. This with an endowment of $200,000 makes the board happy. Miss E. M. Beamish is the superintendent.

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NEW HOSPITAL APPLIANCES, PHARMACEUTICAL PREPARATIONS, ETC.

Ozone in the Hospital

One of the first considerations in a hospital is undoubtedly that of the condition of the air which is breathed by patients and those in attendance. This calls for the most perfect ventilation, especially in wards which are devoted to the treatment of contagious disease. The impurities chiefly met with in indoor air include micro-organic germs, organic effluvia, fumes and gases and dust in every form. The micro-organisms found in the air of hospital wards are very often parasitic and infectious, but may be saprophytic, and these organisms, coupled with the dust held in suspension in the air, form the chief dangers to be contended with.

The great difficulty which has presented itself up to the present in wards and other places has been to keep these particles of dust, which are capable of maintaining the life of pathogenic organisms, sterile, and at the same time to maintain the air in a fresh and breathable condition, without the air being heavily charged with strong smelling disinfectants, which produce a depressing effect upon patients. It is here that one of the greatest uses of ozone has been found; for ozone has anything but a depressing effect upon those confined to the sick room, when admitted to the air in suitable proportions.

It is only of recent years that a means has been devised whereby ozone can be produced in large quantities, free from nitrogenous impurities, and suitable for ventilating.

In a paper read before the Royal Society, February, 1912, Dr. Leonard Hill, M.B., clearly showed that ozone breathed in air diluted 1 part in 1,000,000 was harmless to human beings, and that the best guide to such a concentration was the smell, ozone in proper proportion giving the air a delightful fresh flavor. This effect will be appreciated most during the winter months when the air has to be heated, and in consequence acquires a burnt flavor. This effect can be entirely dispensed with, either by the use of a small portable ozone machine*, or by the introduction of ozone in suitable proportions at the central ventilating plant of the building.

The ozone generated by either portable machines or that of a main generating machine, rapidly diffuses throughout a room or building, entering into combination with any organic impurities suspended in the air, or around the beds, walls or floors, forming more simple and stable compounds and thereby destroying the life of pathogenic organisms. Whole wards can be sterilized in a very few minutes by allowing one of such machines to run in the ward with the windows and doors closed, the time taken depending of course upon the kind of machine used and the size

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of the ward or room. This method is infinitely cheaper and more certain in its action than any of the methods more generally resorted to at present.

The following institutions have recently introduced ozone in this manner for ventilation purposes: The Batley Cottage Hospital, the Glasgow Cancer Hospital, the London Hospital, the Augusta Hospital (Cologne), Institute Pasteur de Lisbon (Lisbon), Institute Pasteur, Paris; Lutheran Hospital, Moscow; Hospital Diaconat, Malhausen Elsass and others.

Another important department suitable for the use of ozone in the hospital is the laundry, the clothes and bedding being subjected to concentrated ozone before being washed and afterwards dried in the presence of ozone. The effect of drying clothes in an ozonized atmosphere helps to give them a whiter texture without injury, and at the same time giving them the delightful smell of linen that has been dried in mountain air.

The use of ozone for the operating room is also to be commended. The pantries of the modern hospital offer another field for the use of ozone as butter, meat stuffs, eggs and vegetables can be kept at much higher temperatures for considerable periods without deteriorating.

The Ormsby New Plant

Canada is to be congratulated that there are those of her citizens who have taken sufficient interest in this vital subject to have had it thoroughly investigated, and she is more to be congratulated in that, once convinced of the absolute necessity that these fire retardants be given to the Canadian public, not as "American-made," but as the result of Canadian industry. They have taken it upon themselves freely to expend their time, capital and untiring energy upon the equipment of a plant almost in the very centre of our City of Toronto, which cannot be equalled anywhere in the world, for the manufacture of hollow steel interior baked enamel finished trim and exterior bronze-covered doors and windows.

They are also equipped to produce many other fireproof materials, such as solid section steel sash, hollow metal windows, fire doors, skylights, cornices, rolling steel shutters and Van Kannel revolving doors.

We refer to the A. B. Ormsby Co., Limited, and their new plant at the corner of King and Dufferin streets, Toronto. Architects and Engineers, Builders and Owners can visit this company and be assured that they will come away with a vastly different idea of the manufacture and importance of present-day fire retardants than any they previously entertained.

That any should fail to accept an opportunity so easy of acceptance and fraught with such tremendous possibilities for the future cannot well be believed.



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A new attitude has been taken about pails for hospital use. Wooden pails are no longer considered proper or serviceable. They are not sanitary, do not last long, invariably leak and fall apart; thus the cost of keeping a hospital supplied becomes quite a large item in a surprisingly short time.

The E. B. Eddy Company of Hull make pails of indurated fibreware by far the most excellent of any yet produced, without hoop or seam, impervious to liquids and apparently lasting a lifetime. They are very light in weight and always in perfect sanitary condition.

The saving of Eddy's fibre pails (and tubs) is an item of much significance, as the articles cost little and wear long.

Any good dealer in Canada will be glad to show Eddy's fibreware, or a letter to the makers at Hull will bring full particulars.

Eddy's "Onliwon" Toilet Paper Cabinet and Eddy's Tissue Paper Towel are two other of their wares of unusual merit and particularly adapted to hospital use.

Electrically Heated Sterilizers

The American Sterilizer Company, Erie, Pa., is prepared to quote on and recommends electrically heated sterilizing apparatus for institutions where for any reason the choice lies between kerosene, gasoline, alcohol and electricity.

Until very recent times, electric heat applied to large equipments, at least, has been considered impossible. The type of heater introduced by the American Sterilizer Company, however, is 95 to 100 per cent. efficient and has proved entirely satisfactory in each of a number of important installations. Perfect cleanliness and simplicity of operation are leading features.

Electric power companies will invariably offer special rates for such apparatus, which makes the cost of operation compare favorably with that of alcohol, and in some cases gas heated outfits.

The Stevens Companies, Toronto, Winnipeg, Vancouver, are agents for American Sterilizers in Canada.

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The Bell Filtration System

Knowing that Hospital Superintendents are keenly interested in the subject of pure water, the following summary of the important features of the "Bell" System is worthy of reproduction. Full particulars can be procured from the company, whose offices are in the Kent Bldg., Toronto.

1. The Bell Filters are simple in construction, easily managed, and are perfect and economical in operation.
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3. The material and workmanship being the best obtainable, are practically indestructible and not likely to get out of order.
4. The filtering material never requires changing, being thoroughly cleaned in three or four minutes with a very small quantity of water, in many cases not 1-3 of one per cent. of the water passed through.
5. The Bell Filter is capable of treating all kinds of waters.
6. Great economy of space, 1,000,000 gallons per day can be purified on an area of 600 square feet.
7. Yearly contracts may be entered into for keeping all plants in thorough working order.
8. Filter plants constructed of any desired capacity, the working and cleaning arrangements being as easily and effectively manipulated in large installations as in small, the compartments being arranged in batteries.

Fairbanks Standard Scales

In cases of medical treatment it is most desirable and often absolutely necessary to note accurately and frequently any small increase or decrease in weight.

A Fairbanks Personal Scale is essential to the Physician, Hospital, Insurance Office, Public School, and even in the household a personal scale is a necessity.

This scale is constructed of iron and brass throughout, with tall pillar, double beam, upper bar, 50 x ¼ lbs., lower, 200 x 50 lbs., with a 50 lb. bottle weight to hang on tip of beam when more than 250 lbs. is required.

Scale is handsomely finished in black and bronze, but may be furnished in light colors at an additional cost.

Scale is furnished with or without measuring rod as desired.

Sanitary Brick Walls for Hospitals

Many of the largest hospitals in the U. S. have adopted "American" Enameled Brick, some of such institutions having been erected for 20 years and still stand, apparently as good as ever, thus proving the enduring qualities of the brick originally used. Could much better proof be obtained?

The Hospital World

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Editorials

A PRESERVATION PAVILION

If physiological science continues to develop along the line of keeping alive organs or tissues separated from their natural environment, hospitals will need to add another building to the many already considered essential.

Dr. Legendre, chief physiologist of the Paris Museum of Natural History, in a recent lecture on

the Survival of Cells and Organs, referred to Carrel's experiments in this direction. He stated that these have been of two kinds—the one, preservation by means of cold. During this latent condition life is simply slowed up or stopped without change occurring, since grafting may afterward be successfully performed. In the other, life is maintained at bodily temperature, and the isolated organ continues to live, but in an independent, peculiar way that permits of no grafting.

In commenting on the former, Dr. Legendre says:

"These experiments in preservation have great practical interest. There is no doubt in fact that they will some day make it possible for surgeons to keep in reserve exchange prices to be used when occasion demands."

This prophecy is not an outbreak of grim medical humor, but a soberly expressed opinion of a well-known scientist. Nevertheless, it opens up a rather appalling vista in cold storage possibilities. Hospital experts and architects will have a new study in planning, when called upon for a Preservation Pavilion to keep in reserve what Dr. Legendre so euphemistically calls "Exchange pieces of human mechanism."

THE HOSPITAL IN THE ASSOCIATION

THE recommendation made at the Boston meeting that the American Hospital Association should be composed of a membership of hospitals, rather than of individuals interested in a hospital, is one so

worthy of endorsation that it should be embodied in some practical movement toward this desideratum.

The first and strongest reason for advocating this change is that no hospital in the country can afford to be without representation at the annual meeting, or to do without the yearly copy of its transactions. This statement is to be taken literally.

The administration of the modern hospital, be it small or large, is a complex undertaking. It is full of many problems and perplexing situations—financial, in its relation to the municipality; professional, in its relation to the medical men; social, in its relation to patients and their friends; and domestic in the running of the house machinery, and adjusting the various departmental details.

Hospitals are at present financed and managed under a sort of hit-and-miss arrangement—each being a law unto itself in its civic relationship. One is wholly municipal, another entirely a philanthropy, a third an educative and university institution, a fourth a blend of all these, while a fifth is purely a corporate or private business investment. Yet these are all hospitals with a common *raison d'etre*—the care and restoration of the sick.

With all these varieties of institutions and problems within them, there is yet no royal road to ideal hospital administration. There is no chair of hospital economics in any of the universities, no lecture course by which a candidate can qualify for this rather undesirable position, no degree or honor to be conferred on the qualified graduate.

A few large hospitals take aspiring students for this work, and give them a measure of insight into the workings of the institution. Outside of this—and perhaps it is the only method—"hospitalists" must learn by doing, failing, comparing notes with other institutions, getting new ideas, new methods and devices—and trying again.

And because of this—because it means so much to every hospital to be alive to the best methods and the new things, it should, as an institution, have one or more representatives at the annual gathering of this national association.

From the economic standpoint alone, it is a hundred times worth while. One single new device in equipment, one new method in domestic detail, or one suggestion in minor construction will often save a hospital thousands of dollars in a year. The cost of construction, equipment and maintenance of even a twenty-five bed hospital is far too large in amount to hesitate one instant where a possibility of obtaining the newest and best in any one particular is involved.

There are some six thousand hospitals in the United States and Canada. There are one thousand members in the Association. A few of these are trustees and members of charity boards, but the majority are hospital superintendents. They are not moneyed men and women. In all but a few cases their salaries are absurdly incommensurate with the skill and responsibility required. Yet these pay the annual fee of five dollars and journey to the Association meeting at their own expense to spend a week of daily session

in serious discussions of hospital problems—great and small. For the larger hospitals there are the larger questions. For the small hospitals there are the many little difficulties that the larger institutions do not encounter. But there are always problems in common; and the Question Drawer provides a means of clearing away many a little domestic difficulty that has been encountered by one superintendent and conquered by another.

It is not fair that this annual post-graduate session of hospital workers should be undertaken at the individual cost of each superintendent. The one or two hundred dollars of expense means often too much to them. It counts almost nothing in the heavy yearly budget of the institution; and the direct return is a hundred-fold in practical and valuable executive suggestions.

According to the figures given above there are five thousand hospitals not represented at the annual meeting. Under present membership eligibility, this condition is likely to continue. The distances are too great, the cost too considerable for the modest salaried officials to undertake it annually or even occasionally.

Again many of these superintendents are only temporarily in the profession. The smaller hospitals are supervised entirely by women—and, being women, they often marry and drop out. The men, laymen or doctors, frequently turn to other more profitable business or to the profession. Contemplating this, or feeling that their position is insecure—which, unfor-

tunately, is a too common condition, they naturally are unwilling to spend money in this direction, especially as the hospital is so largely the beneficiary.

The Association should consist of a membership of hospitals whose privilege it would be to send one or more representatives each to the yearly conference. In event of not being able to do so the hospital would still receive the bound copy of the conference transactions, containing each paper read and debated, each question asked and answered.

These volumes produced year by year form a valuable library on hospital matters generally. The most remote hospital can find answers to all its questions, solution to most of its perplexities and knowledge for its ignorances, within the covers of these hospital blue books.

No hospital can afford to ignore the American Hospital Association or to remain outside of its membership. For the deliberations and activities of this body make for hospital wisdom.

Under the proposed new ruling, the rank of a hospital could be largely determined by the fact of its membership or non-membership in the Association.

THE OPEN HOSPITAL

One of the speakers at the recent Boston Conference, in discussing the question of Open versus the Closed Hospital, said:

"Out West we look upon the hospital more as a business institution. In the East I am convinced that it is considered

strictly a charity institution, and that it is contrary to the spirit of the hospitals there to make them in any way mercenary."

The above statement was part of a spirited debate upon this topic. As a business proposal the westerners stand for opening the hospitals, both private and public wards, to all reputable physicians and surgeons. The best hospitals in the East allow only members of their staffs to treat the patients.

There are, however, a large number of eastern hospitals which restrict the treatment of public ward patients to members of their staff, but admit doctors in good standing to treat patients in the private and semi-private wards.

Eventually the best methods will prevail. No rule can at present be laid down which is applicable to all hospitals; because the organization suitable for one type of hospital will not answer for another.

Let us consider the largest group of hospitals first —the forty- to sixty-bed hospital in the small town, where the medical men, so far as skill is concerned, are on a par. The practice is to give all of them all the privileges of the hospital. This makes for harmony in the profession and tends to promote goodwill in the community toward the hospital.

In the municipal hospital the patients are treated without charge—no fee to the medical attendant being allowed. And the rule for these is a closed hospital. But usually this type of institution has an excessive visiting staff, the members of which are, unfortunately, not all appointed for their scientific ability. In such institutions the average practitioner

is not so anxious to follow his patient in, since the latter usually belongs to the non-paying class.

In the larger general hospitals of the east the staff only are privileged to attend patients. The outside medical man, with reason, feels it a hardship to see his patient, who, he decides, cannot be looked after at home, sent to the hospital and lost to him. And this often means that he also loses the family.

Under such hospital ruling, that member of the staff to whose care such a case is committed, has a fine opportunity to practise the higher ethics—by inviting the outside man to see the case with him, sending him daily reports of progress, and referring the patient back to him at the convalescent stage. Such conduct would do much to lessen the bitter feeling which prevails among the unattached doctors in all our large cities against the closed hospital.

In the debate alluded to one nurse stated that the influx of thirty or forty medical men into a hospital confused the nursing technique. Another nurse remarked, in reply, that since graduate nurses worked under thirty or forty doctors outside the hospital, they might as well do the same while in training. The latter speaker, however, overlooked the difference between a nurse in training and a graduate. While the former would be easily confused by a variety of orders, the trained nurse has been so thoroughly grounded that her technique will not be much influenced by the direction of an incapable physician.

Every hospital administrator, upon whom the responsibility falls of financing his institution, knows

the importance of opening up his hospital to as many doctors as possible. Such a procedure has raised many an institution from a state of bankruptcy to one of prosperity. Unfortunately at the same time the mortality rates will also have increased; also the number of pus cases in the surgical division. An open hospital means one better patronized; and that implies easier finances, which the superintendent converts into better food, better nursing, more competent employees. But these things do not compensate for disastrous professional results.

Such debates as that which arose out of Mr. Olson's paper will undoubtedly tend to improve hospital conditions, and help hospital authorities to decide more intelligently the policy they should pursue when considering medical staff organization.

THE CANADIAN MEETING

It will bear repeating that the seventh annual conference of the Canadian Hospital Association was a marked success.

The programme was excellently varied; the attendance good; and the spirit of the meeting marked by a practical enthusiasm.

As to the papers: The symposium on social service proved that the subject is not yet hackneyed. This topic was discussed from the academic viewpoint by Professor Lloyd of the university; from that of the hospital by Dr. A. K. Haywood, Miss Grant and Dr. E. H. Young; from that of the medical health

office by Mr. Burnett and Dr. Chas. Hastings; that of the medical profession by Drs. Ross and MacMurchy. The summation of the discussion seemed to be that the social service worker should try to abolish the mal-conditions which bring families to the verge of destitution by sickness; and that there should be general co-operation between all agencies looking toward work along this line.

Closely akin to this series of papers came those of Mr. R. M. Bradley, of Boston, and Miss Charlotte Aikens, of Detroit, who have as their slogan "Caring for sickness in the home, and of the home in sickness." Mr. Bradley's keen analysis of the situation, his practical plan for the relief in sickness of families of only moderate means and his possession of the means wherewith to establish bureaus of assistance, bespeak the success of the movement.

Hospital construction was not neglected, as witness Mr. W. B. Stratton's eminently practical paper on Doors, Windows and Floors; Dr. C. K. Clarke's description of the Toronto General Hospital, Dr. John N. E. Brown's views of many of the leading hospitals in the world, and Miss Minnie Goodnow's paper on What a Lady Superintendent Should Know About Hospital Planning.

The training school side of hospital work was kept in the fore by Miss Davidson in her excellent paper on Preliminary Training for Nurses at Technical School; by Miss Aikens in her paper on Problems in Hospital Teaching; and by Miss Ross in her essay on Care of the Incurables.

We shall await with great interest the report of the published proceedings, as they well constitute a most important addition to hospital literature for the year.

The Canadian Hospital Association is an example of what may be done by groups of adjoining states in the neighboring republic.

And such smaller associations will not militate against the American Hospital Association nor the Hospital Section of the American Medical Association.

A HISTORICAL CONGRESS

THE congress of surgeons held in Chicago last month will be always marked as the occasion of the first convocation of the newly founded American College of Surgeons. It is an epochal event in the history of the profession on this continent.

The establishment of the new college is a definite movement toward the standardization of surgery in America and Canada, and only succeeding years can show what this means of uplift to the profession and security to the public.

The existence of such an institution and its requirements will affect both the medical schools and the hospitals. One of the most valuable results, in the latter case, will be a radical change in the methods of hospital appointments to the surgical staff.

In the great number of small hospitals that exist in the country, much major surgical work has been

done by men unqualified for the task—men whose practice is chiefly medical. They do this sometimes, rather than give up their patient to another practitioner; sometimes for the advantage it brings to their practice.

The requirements of a new country occasionally demand emergent surgical service from the man of general practice, but it is not for the good of the community that major operations should be done at intervals by a general practitioner, when surgeon specialists are within reach.

England's experience ought to be reproduced in this country. In England no surgeon can secure an appointment to the permanent staff of a reputable hospital until after he has won his F.R.C.S., and stands accredited with skill, experience and high professional character, by the verdict of the highest representatives of his profession. This method may be expected to be taken up by American hospitals very slowly at first, but it will be adopted in a few years by all hospitals whose purpose is the greatest benefit of the patient. It should presently be true that all hospitals of standing should be compelled to do this.

Both those who enter a hospital as patients and those who, by gift of money establish or help support it, should have all confidence in the high professional standing of its staff. But in spite of high ideals and good intentions hospital staff appointments in this country, up to the present, have been too largely a matter of influence. The favor of the liberal money giver, the push or political ambition of the intriguant

—these are the influences that have too frequently determined an hospital staff appointment.

With no method of standardization, it was almost impossible that it should be otherwise. But with the establishment of the American College of Surgeons, and the fellowships to be won therein, a new force has been set in motion that will gradually educate the public and eliminate much that was both difficult and disheartening in medical schools and staff organization of hospitals.

The movement, since its very recent inception, has advanced with a momentum that is the best proof of the need that has been felt for such a standard, both by the surgeons and the public. It remains for the Regents of the newly established college to make the letters F. A. C. S. a diploma to be most coveted by the profession, and most honored by the public of both continents.

Original Contributions

POINTS FOR INEXPERIENCED SUPERINTENDENTS IN PURCHASING, RECEIVING AND DISTRIBUTING SUPPLIES*

DR. THOS. HOWELL, SUPT. NEW YORK HOSPITAL, NEW YORK CITY

This paper was written for those who are just beginning administrative work as hospital superintendents.

When we go before a board of directors as candidates for the superintendency of a hospital, about the first question that is asked us is "What do you know about purchasing supplies?" or "what has been your experience in buying?"

The board of directors have two important duties. Their first duty is to obtain funds with which to operate the institution, and their second duty is to see that these funds are properly expended and accurately accounted for. The superintendent is their representative and is the person who will spend the money, and, naturally, they want to be sure they are appointing one who will spend it wisely. I think, however, that they rather exaggerate the importance of this function of the office.

The superintendent has other duties, that in my opinion, are much more important. But, inasmuch, as our trustees lay stress upon our ability to purchase supplies, it behooves us to become proficient in this respect.

I have always contended that any person of fair ability and reasonable financial sagacity could soon learn enough about purchasing to handle this department of the hospital successfully.

In a general way the superintendent should know how goods are sold; what the selling units are; the best time to make purchases; which supplies should be purchased in large amounts; which supplies should be purchased by contract; and which supplies should be inspected before purchasing.

In buying it is not well to pretend to have knowledge which we do not possess. It is much better to make the dealer share part of the responsibility of our selections.

* Read at the meeting of the Canadian Hospital Association, Toronto, October, 1913.

When we buy without asking the dealer's advice, acting entirely on our own responsibility, we have no legitimate claim on him if the goods do not turn out as well as we expected.

It is well to have a guarantee when the commodities are of such a nature and of such an amount that a guarantee is a reasonable thing to require. But do not be too fussy. Business men do not like the fussy or mean buyer; they do not care enough for his business to place him on their list of favored customers.

Do not have too many dealers in any line. Where you have a large number your business will be so divided and scattered that it will not amount to much to any of them, and they will not be so anxious to please and satisfy you.

If your purchases are considerable in amount dealers will use every effort to merit a continuance of your patronage, and you may rest assured that they won't try to cheat you.

It is probably wise, however, to have more than one dealer in each line. It will forestall criticism on the part of the critical and suspicious. Certainly three responsible dealers will furnish you all the competition that you need in any line.

Another objection to buying from too many houses is that you are likely, in order to get low prices, and also to distribute your business among them, to overbuy.

Ordinarily, it is better to have too little stock on hand than to have too much. Where you have a large supply on hand there is a strong tendency to disburse it too freely.

Remember always that shrewd buying will not compensate for carelessness in the issuing of supplies. It is a case of pinching pennies and scattering dollars. You can buy no cheaper than other superintendents, but you can save more than most do. Economy in the use of supplies is one of the most important things we have to learn.

Many commodities are sold at fixed prices. That is, the manufacturers or jobbers in selling to the wholesale and retail merchants insist that these merchants shall all charge their customers fixed prices for certain quantities.

These fixed prices are a comfort to the amateur purchasing agent. He knows that he is getting as good a price as anyone is, and this is a source of satisfaction.

Most of the advertised goods are sold at fixed prices. When it comes to the purchase of goods of this class, you will naturally learn to use the telephone in placing your orders.

BUYING BY TELEPHONE.

A word about purchasing by telephone. The telephone is an extremely useful instrument to use in purchasing, but it must not be used to the exclusion of market visiting.

Visit the market, especially the fruit and vegetable markets, at least once a week. In this way you will learn what is seasonable and what is cheap. And you will also add to your knowledge of commodities. You will also frequently pick up excellent bargains. And above all you will be cultivating a valuable acquaintanceship.

We hear professional buyers object to purchasing by telephone. Some of these objectors are purchasing agents who I have often thought go into the market daily, largely for the purpose of filling in their time.

It does not require much time to do the purchasing for a hospital. One superintendent who bought for three large institutions, and who is an excellent business man, said that he did all of his buying in two or three hours a week.

My experience as a purchasing superintendent has been quite similar. I found buying merely a pleasant pastime.

OBTAIN GOOD WILL OF BUSINESS MEN.

It is excellent business policy to obtain the good will and respect of the local business men. In times of trouble, investigations, etc., they are likely to prove loyal supporters. I know of more than one institution that has been saved from being held up to public ridicule through the assistance rendered by these men.

In order to induce their customers to make prompt payment, most dealers, jobbers and manufacturers give small discounts when goods are paid for at delivery, or within ten or thirty days The discount will vary with the class of goods. The more prompt the payment, the larger the discount is likely to be. There will be one discount for cash, another for ten days, and still another for thirty days. Dealers are more likely

to quote closer prices when they know that they will not have to wait for their money.

My advice to you is to watch your discounts carefully and to obtain them wherever possible. In this way you will make a very respectable saving for the institution. At the New York hospital we save about $1,000 annually by taking advantage of all discounts.

AS TO TRAVELLING SALESMEN.

There are some superintendents who refuse to see salesmen, claiming that doing so is a waste of time. I do not agree with this. Some of the most valuable information that I have obtained about commodities has been from the travelling men.

These men are very anxious to sell goods. While they are employed and paid by another person, still, in a certain sense, they are working for you. Sometimes, in fact, it seems as if they worked harder for the customer's interest than for their employer's.

Thy will give you inside information, and will protect your interest in various ways. It has been my experience also that they frequently give lower prices than is obtained by visiting their houses.

BUY STANDARD GOODS.

It is very poor economy to order inferior goods. The introduction of this class of goods into the institution means increased waste, and therefore increased expense.

The cook will throw your cheap meat into the garbage can; the nurses and help will soon break your cheap furniture; the patients and employes will, naturally, complain about your cheap butter, eggs and bread; and pretty soon your Board will be getting adverse reports about its cheap superintendent.

I don't mean that we should pay excessive prices for fancy goods; this is also a mistake.

Foodstuffs in particular should always be of good quality. Furniture or articles that are to have long, hard usage should be carefully selected with regard to durability.

But in the case of such articles as gauze, scratch pads, safety pins, and a host of others, which are used only once or twice and

then thrown away, it is well to select those that are inexpensive. It is also well not to pay too much for bottles, tumblers, china, crockery, etc., where the breakage is excessive. At the New York hospital the breakage of chinaware and glassware, not including prescription bottles, is about $1200 a year.

Pay a reasonable price for food supplies, but insist upon getting what you pay for. You will spend very little more than if you adopted the cheap policy, and you will save yourself much trouble and disappointment. Moreover, your employes will be happier, more contented and more productive.

BUYING BY CONTRACTS.

Some hospitals buy on contract. The hospital enters into an agreement with the dealer, whereby the dealer is to furnish goods complying with certain specifications, for a stated price. Provision is made in the contract that goods when not according to specifications are to be removed from the hospital by the dealer without expense to it.

The municipal hospitals buy on contracts pretty generally. This is done to prevent graft, but I am not sure that it does do so.

There are many excellent business men who believe in hospitals contracting for most of their supplies. They claim that more favorable prices are obtained by so doing.

But, as a general proposition, I do not believe in contracting for hospital supplies, except for a few which are purchased in large quantities such as coal, gauze, canned goods, printed matter and ice.

I believe that very few hospitals purchase a sufficient quantity of goods to make it profitable for dealers to give them very low prices on contracts.

For the ordinary institution to contract for such supplies as meat, fruit and groceries, is simply to gamble on the other fellow's game. While the prices stay down and the contractors are winning, they may furnish the goods contracted for, but when the market goes against them, it is only human nature that the quantity or quality (one or both) should suffer.

Shortage in quantity may be guarded against by weighing, counting or measuring all goods received, but it is exceedingly

difficult, owing to ignorance, carelessness, or even dishonesty on the part of the receiving agent, to guard against the delivery of goods of inferior quality.

If contracts are drawn they should be submitted to an attorney for an opinion as to their legality.

I have found in purchasing by contract that some dealers in order to secure the contract will underbid their competitors to a marked extent with the expectation of forcing inferior goods or short weight upon the institution.

When you buy on the market from day to day the dealer is in a sense your friend, and ordinarily will endeavor to protect your interests, but when you enter into a contract with him your interests are no longer identical. The relations of the parties to a contract frequently become strained.

It has been my observation that where it is possible it is best to buy the same grade of goods for use all over the institution. Some institutions buy different grades of butter, coffee and bread for their officers, nurses, employes and patients. This is a serious mistake, and lays them open to the charge of buying one class of goods for their officers, and another for their patients.

It is a nice thing to be able to say to visitors, when showing them through your kitchen, that you buy only one grade of coffee, one grade of butter and one grade of tea, and that all persons in the institution receive the same quality. It gives them a pleasing impression of your institution.

Never hesitate to return goods which are not up to standard. By so doing you may convince the dealer that you are not to be imposed on, and perhaps will increase his respect for your knowledge of values.

Whenever possible, buy direct from manufacturers. This is particularly advantageous in the case of cotton goods.

CO-OPERATIVE BUYING.

Some three or four years ago there was organized in New York City a purchasing agency. It is known as the Hospital Bureau of Standards and Supplies. Its membership includes twenty-five or thirty of the leading hospitals of New York, New England, Pennsylvania and Maryland.

As its name indicates, this Bureau not only purchases supplies but it also aims to standardize those articles which are used generally by hospitals.

Very satisfactory results are being obtained. The hospitals of Syracuse, N.Y., recently got together, and are co-operating in the purchase of supplies. It seems to me that this is a move in the right direction. Hospitals can lose nothing and may gain much by co-operating in purchasing.

THE PURCHASING AGENT OR STEWARD.

The hospital steward may have other duties than purchasing supplies. He sometimes has charge of the clerical force. Frequently he has supervision of the kitchen, hiring and dismissing persons employed therein.

He may get up the menus. If there is a farm connected with the institution, he probably will have charge of it. He may have charge of the repairs. General hospitals rarely employ stewards. The insane hospitals almost invariably have a steward and his duties are as just outlined.

The general hospital is more likely to employ a purchasing agent, and in addition to buying supplies he will probably have general charge of the storeroom He will buy under the direction of the superintendent.

He visits the market, gets quotations and places orders. When the goods are delivered he inspects them as to their quality. When the invoices come in he will approve of them as to price and terms.

For his own convenience he will keep a card catalogue containing pamphlets and catalogues of manufacturers and dealers.

THE STOREROOM AND THE STOREKEEPER.

The stores may be all received and stored in a central storeroom which will be under charge of a storekeeper. Or there may be several storerooms in different parts of the institution.

Small and medium-sized hospitals will, ordinarily, have several storerooms and they will be under charge of the matron, directress of nurses, pharmacist and other officers.

The matron will have charge of the dry goods, crockery and

the food supplies. The directress of nurses or pharmacist will be held responsible for the surgical supplies, including instruments.

In this way the salary of a storekeeper will be saved. I say saved, advisedly. I am convinced that a hospital of moderate size does not need a storeekeeper, providing the heads of the departments are faithful and honest, and they usually are. Ordinarily, the loss of supplies from carelessness and dishonesty will amount to less than the salary of a storekeeper.

If the institution is a large one, then the services of a purchasing agent and a storekeeper are necessary. Considerable care should be exercised in filling these positions for they present opportunities for petty graft. Select honest men and pay them sufficient to keep them honest.

If the institution has a storekeeper, what are his duties? I would enumerate them as follows:—

To arrange his stock neatly and methodically.

To keep the superintendent or purchasing agent acquainted with the amount of stock on hand so that orders may be placed at the right time.

To receive and weigh, measure or count all supplies, reporting all discrepancies.

To keep a list of goods received.

To maintain a card index, showing goods on hand, when received, amounts disbursed, when disbursed, and to whom delivered.

He will deliver supplies only on the presentation of a properly signed requisition. He should be allowed no latitude in this matter. The requisitions keep a check on the stock and also curb the storekeeper's generosity.

He will certify each bill as to quantity and quality.

In some hospitals he will act as butcher, and he may have charge of the kitchen.

RECEIVING OF GOODS.

Where the institution is large, and a single storeroom is maintained under the supervision of a competent storekeeper, it is best to have all goods received by him.

Where the heads of the different departments have charge

of the stores they will also act as receiving clerks. That is, the chef would receive food supplies, the matron dry goods, crockery, etc.; the engineer, supplies for his department, and the carpenter will receive the lumber.

INVOICES.

Invoices may accompany the goods, or may be received daily, weekly or monthly.

I think that it is best to have the bills mailed just as soon as the goods are shipped. In this way you will be able to check up your bills before the goods have been distributed, and while the transaction is still fresh in mind.

If you receive your invoices only once a month you will find very frequently that the goods have been already sent out, and there is no way of correcting discrepancies.

I think that, ordinarily, it is best to have the invoice mailed to the superintendent, and not to the storekeeper or head of a department.

On the receipt of the bills he should hand them to the head of the department to be checked up, or better, he should have the storekeeper, or the heads of the departments, send in daily the list of goods received, in order that he himself may check up against the bills received. To sum up:—

Buy carefully but not parsimoniously.

It is poor economy to purchase inferior grades of food, furniture and instruments, etc.

Keep on hand as small a stock as is consistent with the exigencies of the service, as, where large stores are kept the tendency is toward extravagance in disbursement.

Issue supplies only on the requisitions of chiefs of the departments, and keep these chiefs thoroughly informed as to the expenses of their departments.

Require where possible when a new article is requisitioned for that the worn one which it is to replace shall be turned in for exchange.

Pay salaries commensurate with the service rendered.

Do not patronize too many dealers in any one line.

Remember that economy in using is much more important than economy in buying.

Society Proceedings

SEVENTH ANNUAL CONFERENCE OF THE CANADIAN HOSPITAL ASSOCIATION

NEW CLINIC HALL, TORONTO GENERAL HOSPITAL.

Toronto, Ont., October 20th, 21st, 22nd, 1913.

EVENING SESSION, OCTOBER 19th, 1913.

THE PRESIDENT: I see the first thing is the reading of the Minutes. We will take the minutes as printed in the last report.

It next falls to my lot to read the Annual Address.

(Reads Address). (Applause).

We regret very much the absence of one or two people on our programme who were to be among the chief speakers this evening, but they have been unavoidably called away. We hope there will not be any other breaks in the programme. Dr. Howell, President of the American Hospital Association, wrote me that it was simply impossible for him to attend. I wrote him a second letter, and he said "I cannot possibly be present." So Dr. Young, of Rockwood Hospital, has consented to read Dr. Howell's paper:* "Points for Inexperienced Superintendents in Purchasing, Receiving and Distributing Supplies."

(Reads.) (Applause).

THE PRESIDENT: Dr. Howell's excellent paper is open for discussion. I hope we will have a free discussion on these papers. We would like to hear from some of you. It may be perfectly simple to some of us, but to others it may be more difficult, and some may have a simpler way of doing it which will help others.

MR. JOHN ROSS ROBERTSON: Mr. Chairman, rather than let the discussion go by default I would say that I think there is a great deal of truth in the remarks made by Dr. Howell in his paper. Of course there is a large difference of opinion on the question of buying supplies. Some hospitals adopt one

* See pages 334 to 342 this issue.

method, other hospitals another. In the hospital that I have the honor of being connected with, the principal articles—those that are required in large quantities—are bought by tender, but the smaller, the articles that are bought in smaller quantities day by day, are bought by the steward of the hospital, who in consultation with the Secretary, submits the prices, and the persons, if possible, that we are to buy from. Dr. Howell, whom I have the pleasure of knowing, refers to the Purchasing Bureau in New York City, through which supplies are bought for nearly all the principal hospitals in New York, and I think in some of the adjoining States. I remember when this bureau of purchasing was inaugurated some years ago. It was discussed, I think, at a meeting of the American Hospital Association, and doubts were expressed by some that it might not, that it would not, be easy to carry out; the theory was all right, but in practice they might not be able to carry it out; but from what I have learned I have found the idea has worked out to great advantage and that quite a lot of money has been saved by the institutions by the efficiency and the knowledge used by those who made the purchases under the auspices of this Association. As far as Toronto is concerned, I doubt very much whether such a bureau would be effective. We have two or three large hospitals, and we each have our own methods. For instance, in connection with the Hospital for Sick Children, we would just have to—well, it would mean a complete change, we have been working on our present system for the past twenty-five or thirty years, and we have found the plan to work out all right. I agree with the Doctor when he speaks about economy in using; it is a great essential. Of course economy in buying is an absolute necessity. In another part of his paper, or your paper, where you refer to the buying of necessaries in large quantities, I think that sometimes it is perhaps preferable to buy in smaller quantities, because the buying in large quantities induces perhaps the officials to use the stock with too free a hand.

I think that Dr. Howell has covered a lot of ground, I think in your address you covered a lot of ground. I think, Mr. Chairman, there is enough meat in that address of yours to keep us going in the line of discussion for about a week.

You said a good many things, and I think they ought to be discussed. My friend, Dr. Young, says, "Hear! hear!" It just reminds me of an allusion, if you will pardon me for digression, to a paragraph in your own address, Mr. President, where you refer to the Proprietary Medicine gentlemen who flood the country with pamphlets and use, I suppose, the newspapers for advertising their wares. I think there is this to be said with regard to that. Of course the public have no control over the number of pamphlets that are issued and printed and sent through the post to the addresses that are furnished by directories, but I can say this as a newspaper man that a great many of the newspapers—in fact, it is the aim of perhaps all newspapers—but I know this, that a great many of the daily newspapers in Canada, and perhaps in the United States, publish at least clean newspapers, newspapers that can go into the house of every citizen and that a child of seven or eight years of age can read from headline to the end without finding anything in them that would be unclean. Now, as I said before, I do not want to throw any bouquets at myself, but I do want to say this, and I think it is only fair I should say it, because I believe the ladies and gentlemen here would appreciate what I say: I am not alone in the application of the remarks that I am going to make, that in regard to patent medicine advertising, a great many of the newspapers in Toronto have thrown out—at least have edited the patent medicine advertisements that have come before their advertising managers; and I know that in the case of the *Evening Telegram* in the last eighteen months we have rejected over $12,000 worth of advertising; $12,000 of solid gain that we have refused to accept because the advertising was not clean. Well, there are other newspapers in Toronto that I believe are doing the same thing, and I believe the effort all over the country is to try to keep the newspapers clean so as to avoid what the Chairman has pointed out, the flooding of newspapers with advertisements and the country with pamphlets and booklets and other forms of literature that certainly should be consigned to the wastepaper basket.

I think the address by the President was a very excellent address. I was unfortunately not in Boston as I was in

Europe, but I have been to the American Hospital Association meetings for a great many years, and I do not know if I ever heard an address that contained so much meat as the address our President has given us to-night. (Applause).

Dr. J. N. E. Brown: We are all very much interested in the President's Address and in the succeeding paper read by Dr. Young. I do not know why the custom is in vogue of refraining from discussing Presidential addresses. I think the Address is one that raises a great many points, that, as Mr. Robertson said, might well be talked over by this Association.

Referring to Dr. Howell's paper, which certainly is an excellent one, I may say that Dr. Howell has made a special study of the subject of his paper. I recall some years ago visiting the hospital of which Dr. Howell has charge to learn something of their methods of buying and keeping track of their supplies. After making certain enquiries it seems to me that they have the best system of any hospital in America, and that was the reason I went there. The hospital at that time was under the superintendence of Mr. Ludlin, a very capable man. Dr. Howell, of Worcester, succeeded him, and I understand has made some improvements on the methods which Mr. Ludlin had inaugurated in the New York Hospital. Those of you who would like to find out something more of the subject of the bureau of supplies can do so by writing to Dr. Howell or any of the New York men for a little pamphlet which gives a description of how the New York hospitals do with respect to their buying. This bureau will extend the courtesies of the purchasing of supplies to other hospitals in the United States provided the amount purchased each year comes to a certain sum of money. I do not know whether it would pay Canadian hospitals to endeavor to take advantage of that offer. Perhaps the duty would make it not worth their while. But it occurred to me that something this Association might do would be to consider the question of having all the hospitals in Canada, or at least all those in Ontario, combine together and appoint one purchasing agent here in Toronto—perhaps Mr. Robertson's steward or the Purchasing

Agent of the Toronto General Hospital, who are buying so largely and I have no doubt would make better bargains—if the fifty or sixty hospitals in Ontario would form a small committee it might be possible for you to start a bureau here and thus save a good deal of money to the hospitals of Ontario. Something can be learned too from the Provincial Secretary's office, two representatives of which I see here. I understand they have also a particularly careful system of buying and issuing supplies. This paper of Dr. Howell's is a very commendable one, and I am glad to know that we will all have the opportunity of reading it over carefully in the transactions which will be published.

Referring a moment to the excellent address of Dr. Boyce, as to what hospitals should do to serve the community, I think there is a good deal to be said on that. We should let the general public know a great deal more than we do of what goes on in the hospitals. I think we should assist our medical students more than we do. I think the rural hospitals out of Toronto should secure to their senior graduates the privilege of going into the hospitals and getting some practical experience, following up their course by a year's practical experience in the hospitals of the Province. I think too—referring to that point a moment longer—that it would be better if our physicians and surgeons were trained better. One reason the fakirs and charlatans succeed is because our own medical profession is too ill-trained. Only yesterday I was talking to a gentleman who had consulted some of the medical men for certain common infections—the case had not evidently been properly diagnosed—he said an old Indian told him to take a tablespoonful of turpentine and inhale the fumes. He said he got very giddy and did not repeat the experiment. It seems to me that, if our medical men were better trained, there would be fewer of their patients who would be inclined to treat with these charlatans. Then I think, too, the hospitals should assist in the rural nursing. This appears to me to be a great problem. The people of the rural communities do not know yet the value of a trained nurse. About twenty years ago, after graduating from here, I was called to a farm house to look after three cases of smallpox. When I arrived there

I found the mother—it was in a German community—the mother was lying beneath a feather tick, a great feather tick on top of her. It was the custom, I believe, in that family to sleep with those feather ticks over them, and I can assure you I was not very happy until I secured a nurse from Toronto to handle it. An Irishman came to this country and he wrote home and he reported the good job he had, and he said he had nothing to do but merely to carry up hods of bricks eight stories and there were men up there to do all the work. The nursing problem is one that is a very important one in the country places. I think if nurses are introduced in the country places and they learn how much value a trained nurse is it will do a lot of good. In some places a medical man has what is called a practical nurse; some friend of the family comes in who does not do it very effectively or efficiently. I think we will hail the day when there will be trained nurses in every country community in Canada, and I think we can help to bring that about. Thanking you for the opportunity to speak. (Applause).

Mr. Vaughan: Some time ago I wrote to the Bureau of Hospital Supplies, New York, to see if Canadian Institutions could benefit by their arrangement and they said they did not think so. They said they went into it with fear and trembling. It went on for year after year and they said it was not only for New York, but for surrounding States, and I do not see why if it is successful there it cannot be in Toronto and the surrounding territory.

Mr. Robertson: I think we ought to put on record our testimonial to the excellent address of the President, and I have very much pleasure in adding to the remarks I made a motion of thanks to the President for the very able and excellent address that he has delivered. (Seconded by Dr. Young).

Dr. W. A. Young: In that connection, Mr. President, permit me to say that the remarks you made in connection with the sale of certain patent medicines are very much to the point. There is no question that it is getting worse and worse every year. Recently I had to preside over an inquest,

the case of a young girl who died in Toronto, which resulted from taking a certain medicine that was purchased in a drug store. In going into the matter I found that the trade here in Toronto was increasing at a great rate, that a certain class of druggist who has to make a living, no matter how, are selling great quantities day by day. Young girls suffering from their own indiscretion can go into any drug store and purchase at any time these so-called remedies, and very frequently at that. I found that the Criminal Code, at least in the opinion of a very prominent counsel down town, should be amended. At present any druggist can sell any of these remedies over the counter to anyone without any record having been made. Is it not time that this Association should take a hand in the matter and if necessary approach the authorities at Ottawa and, if possible, have an amendment made to our Criminal Code making such impossible. The Criminal Code is now so worded that in order to make that druggist liable it must be shown that he has a guilty knowledge of what that remedy is being sold for; in other words, that you must show that he knows that that preparation is going to be used for the purpose of bringing on an abortion; otherwise he cannot be convicted. It seems to me that this Association could do a great work, if our Secretary would take the matter up, in rendering such sales at least more difficult, and, if possible, illegal. I would like to second Mr. Robertson's vote of thanks to the President.

Dr. W. J. Dobbie: Knowing as I do the customary diffidence of the President on such an occasion as this I shall take the opportunity of putting this motion to the Association. (Carried unanimously).

We tender to you our hearty thanks, and if I were to take this opportunity to say anything else I would say that practically the whole programme of this Association is the individual work of the President.

The President: I thank you, ladies and gentlemen.

The next subject on the programme is not on the programme. (Laughter). Is Dr. Porter here?

Dr. Brown: He is not in town, I understand. Dr. MacMurchy will read Dr. Amyot's paper, who is unavoidably absent.

Dr. Helen MacMurchy: (Reads paper).

I am charged to express to you the great regret of Dr. J. W. S. McCullough, the Chief Health Officer of Ontario, and Dr. Amyot, the Chief Bacteriologist of Ontario, in their absence. Every arrangement was made by both these gentlemen to be present and their papers were prepared, but neither of them is accustomed as a rule to give a typewritten paper at a meeting. They have rather prepared the notes than the form of address, and on Friday they received a telegram from Washington calling them away at a moment's notice to a meeting of the International Boundaries Waterways Pollution Committee. I think the ladies and gentlemen will remember that Dr. Amyot was appointed to that Committee and that Dr. McCullough is also a member of the Committee. They were obliged to go, and that is why they are not here to-night. Dr. Amyot just before he left wrote down hurriedly in pencil a few notes of his address and asked me if I would present them to you this evening, which I have great pleasure in doing. Dr. Amyot's subject is "Sanitary Precautions in Hospitals."

(Reads paper).

Amongst those that need the hospitals' help most are often the very sensitive, the frightened, those that hear horrible things about hospitals. The parents consider them above all their other possessions, even their own lives. Be kind, very kind to them. Remember they do not know why or how you are going to do things. Do not be afraid to forget the rules now and then when it can make things easier for them.

The President: I do not think there is a subject that requires so much discussion and consideration as the one that has been taken up by Dr. Amyot, so I hope that we shall have a free discussion on this subject, and I am sure the reader of the paper, if I remember rightly, some two or three years ago wrote a very able paper on milk and I am sure she will be able to discuss this part of the work very fully. So this paper is now open for discussion.

Dr. Clarke: The points brought out in Dr. Amyot's paper are so obvious to all hospital people that I do not think there is any room for discussion, as the modern hospital that is not equipped on all these points is not up-to-date. Unfortunately we are being troubled here a little with flies, but we hope to have them all out in the course of a few days. So if you notice any while going through the hospital you will realize the fact that we are after them. We have not got them all. But all the other points I think are demonstrated in this hospital. All the new flies are pasteurized most carefully, and I think you will find other suggestions in the Sick Children's Hospital next door. I think they handle the milk supply most perfectly there. As far as the sterilization of dishes, etc., is concerned, I hope the members will take every chance to study all the points around this hospital. The hospital is open to all of you, and if there is any point you want elucidated, we will give you every opportunity to acquire all the information you wish.

Mr. Robertson: I might just as well get up now and discuss this thing. My friend Dr. Clarke, the Superintendent of the General Hospital, as well posted a man as there is in the community on hospital work, referred for a moment to the fly business, (Laughter) about swatting the flies. I did not rise to speak on that subject because that is of importance to me. I do rise to say that with regard to flies we had three hundred and fifty-five children on the Island for four months and ten days, and I think for all that time there was no fly to be found because the building is screened from attic to cellar, because it is screened all over.

Now, in regard to another matter, and I do not want the ladies and gentlemen here to think that I am here to sound the trumpet for the Sick Children's Hospital, but I have taken some little interest in hospital work for the past thirty years, and I want to say in regard to pasteurized milk that there is only one form of absolutely scientific pasteurized milk and that is the milk that is pasteurized by the pasteurizing plant of the Hospital for Sick Children in Toronto. The milk is pasteurized according to the same methods employed by Nathan Strauss on East 22nd Street. About three or four years ago some of us visited New York with the intention of looking

into this milk question, and before we left New York I left an order for a plant, and that plant has been in operation in the Hospital for Sick Children for I think about three or four years. In the new addition that we are making to the Hospital we are pursuing exactly the same policy.

There is pasteurization and pasteurization. You pasteurize milk in bulk; that is commercial pasteurization; and I think that men who do commercial pasteurizing should be subject to the Criminal Code. We pasteurize not bulk; we pasteurize certified milk. Our certified account runs from two thousand to three thousand, and when we pasteurize that milk and deliver it to the storage plant the account is zero. and there is no other milk in the Dominion of Canada pasteurized in that manner. The system is simply that certified milk—not bulk milk—where the account sometimes runs as low as seven hundred—you know what I mean—it is subject for twenty-five minutes, I think, to one hundred and forty, and then it is put in cold storage. It is pasteurized in the bottles. This pasteurizing of milk by the hundreds of gallons, that is commercial pasteurization, that is not pasteurization at all. Of course our plant is in operation, the old plant, but we are putting in an improved plant in the new building that will make our pasteurization—it cannot make it any better—but we will be able to handle at a less expense a larger quantity of milk. Why, the pasteurized milk from the Hospital for Sick Children that was used for three years at the Sick Children's Home in Toronto almost eliminated intestinal trouble. Why we have done more in the saving of baby life in this city through our milk depots that we supply throughout the City than we do by the most effective work of the physicians in the hospitals, and I am only sorry that this meeting was not held three or four months later so that we could show you next door to this great hospital a plant like this. Of course our work is comparatively small compared to that of the great hospitals. Last year we handled twenty-five thousand cases in the outdoor, at least twenty-five thousand cases, and I fancy there must have been eight or ten thousand of them babies. We supply this milk to a dozen settlements around Toronto and they are all doing excellent work, as the

result shows, and every one of these cases is followed by our motor service, and a district nurse who used to handle ten or twelve patients a day visits now twenty-five or forty and travels forty miles a day in the motor service in Toronto.

But that is a kind of side talk for the Hospital for Sick Children. I want to impress upon you that we are doing our level best to give the children pure milk, and I think my friend from Detroit, Michigan, referred a moment ago to a paragraph in one of the addresses on nursing. Well, the want of nursing. Why bless your heart, they are trying to supply the nurses required all over the Dominion. Why all you have to do is to look up the daily papers and find the correspondence schools that have started in; they do it in six weeks (Laughter). Without throwing any bouquets at the *Telegram* I can say that we do not insert such an advertisement. We are prepared to fight. We are conducting a fight in this country against the correspondence business. But they are hard to get at, especially when you have members of the medical profession in Toronto partners in these schools, and you have a medical council here that is supposed to discipline these gentlemen. Why, if the council hears of a man on their roll being connected with a correspondence school they do not dare to raise their fingers. I think the Ontario Government is going to appoint someone in the next month or two. The whole question will be revised and put in such a form that my friend cannot go up to Dr. Bruce Smith—if Dr. Bruce Smith was here tonight I would like to tell him of one school that he gave a charter to that he should have looked at twice before he gave a charter to it. I met a young woman the other day who had spent $85 in going to this school and she was in it about six weeks, and she did not know half as much about nursing as I did. (Applause).

The President: Any further discussion on these papers? Let us hear how some of the smaller hospitals are doing, whether they sterilize milk, or the methods employed. We cannot all afford large sterilizing plants that cost a great deal of money. Perhaps some will be able to tell us whether they sterilize their milk, or what methods they employ.

Mr. Robertson: If any representative of the smaller hospitals will come over to our plant, our Superintendent will show any of them how to pasteurize this as we do. All you have to do is to buy the ordinary plant. They are sold in New York City. You can buy them here. I bought three or four at $3.50 and $4.00 apiece. You can use it in your home or you can use it in the hospital.

Dr. Helen MacMurchy: I quite agree with Dr. Clarke that the points in Dr. Amyot's paper are obvious. I would like to say a word or two about the house-fly. There are screens and screens, and in some institutions lately, not hospitals, it seemed a pity to see the ingenuity and time and money spent on ineffective screens. There might just as well be no attempt at screening at all. The screens in the Toronto General Hospital are rather nice, we think, and perhaps in going through the hospital it might be worth while to spend a minute or two in looking at the screens. They are remarkably simple, and I think perhaps did not cost a great deal and are very effective. In a house of refuge in Ontario, not a costly place at all, Mr. President, but suitable and comfortable and where the inmates look happy—which is perhaps the greatest thing of all in an institution, next perhaps to cleanliness—in this House of Refuge it was very interesting to see what one of the inmates, a carpenter of about sixty-five years of age, had done for the institution. He was a nice, good, intelligent carpenter and he felt in that House of Refuge that he had a home there and took a pride in it. It is not in every House of Refuge you find that. This carpenter at the age of sixty-five had made splendid screens and had done it, too, very economically. Every door and every window in that institution had screens that fitted them just as well as the excellent screens in this institution, and they had been made by him in the course of a few months, and all the doors and windows in the place were screened in this way. However, of course, screens are not the only thing that has to be considered. It is to prevent the coming of the flies at all; not only, as Dr. Clarke says, to get the first one or two or the last one or two that there are, but to see that they are not present in multitudes outside, that when the

door has to be kept open a minute or two it lets in a multitude of flies. This is of extreme importance. There are very few hospitals in Ontario where we did not see at least a few flies, especially in the sick wards of charitable institutions. It is a very serious matter. Dr. McCullough has issued an extremely good circular on this question, and I hope that before long some of the other Departments in the Government will issue a regulation of the absolute necessity of keeping flies out of our institutions altogether. I think they are the most dangerous animals. The study of the fly now interests a person as it did not used to at all.

Dr. Brown: In reference to what Mr. Ross Robertson said a few minutes ago I think we will all admit that there is no man in the Dominion who has been kinder to children than Mr. Robertson, and when he gets to Heaven, if he ever gets there, it will be through his work in the Hospital for Sick Children. Not long ago one of these schools had the impertinence to send a circular letter to every physician in Toronto asking them to subscribe to stock. I took the occasion to criticize them rather severely in the *Canadian Journal of Medicine*, and the result has been as I intended, that the physicians who were connected at that time with the School of Nursing have since resigned. It was only a few years ago that these schools were ripped to pieces for their financial business. I understand that Sir James Whitney has been working on his Bill which will include the subject of rendering it impossible for such institutions to exist.

The President: I understand Dr. Porter is present. We would be pleased to hear his paper.

Dr. Porter: Mr. President, ladies and gentlemen, I assure you I feel very highly the honor of taking Dr. McCullough's place this evening. I have been absent these three weeks out in the West where this paper was presented and it is at the request of Dr. McCullough and your President that I present it again. It is simply a short paper on Tuberculosis, and as you know the subject of Tuberculosis is of such a nature that it makes it difficult to cover and therefore I intend to express it in nautical terms instead of technical.

(Reads paper). (Applause).

Ladies and gentlemen, assuming this picture roughly represents the Tuberculosis situation, are we not justified in urging all those in difficulty to make for an early place on one of these simple but seaworthy rafts, and are we not justified in urging the Government and the people and the Health Authorities to provide full and ample capacity for them all?

THE PRESIDENT: Ladies and gentlemen, I am sure we are deeply indebted to the reader of this paper, Dr. Porter, for the very interesting and original way in which this has been brought before us. I believe I am stating facts when I say I never remember hearing a more interesting paper on this subject, put in such an interesting way and in such a way that we will not soon forget, and I hope and trust that there will be very few of the patients in this Province embark on that weak turtle. I hope that this man who is spoken of, or at least had this serum brought out, will not bring any more around this part of the country. I think that it has perhaps been tried in the balance and found wanting. This interesting paper is open to discussion by the members. Dr. Dobbie is very much interested in this subject and we would be pleased to hear from him.

DR. DOBBIE: Mr. President, ladies and gentlemen, I certainly think that it would be very much like presumption on my part to attempt a discussion of Dr. Porter's paper. It takes one very much unaware, his method of looking at the subject, and yet I think he embraces all the important facts that there are at the present time in connection with the subjects of Tuberculosis. While I may be presumed to be somewhat familiar with the subject, I may say that it perhaps took all of my attention to be able to navigate with him those difficult waters which he described so beautifully to us. I have no doubt that Dr. Porter's paper will be read perhaps more widely than would one written in the ordinary dry and commonplace way in which papers on Tuberculosis are generally presented, and for that reason I think we are very fortunate to have the opportunity of adding it to the proceedings of this Association where it may be perused again by all of the members at their leisure.

While I am on my feet I might perhaps say that the subject of Tuberculosis is one which touches a great many of the topics which have been discussed to-night. Particularly in relation to sanitary measures of different kinds I want to ask a question in which I am particularly interested and one especially in which I am desirous of getting information from perhaps Dr. Clarke or someone else. In the institution with which I am connected we dispose of our waste products from the kitchens and tables by feeding them to hogs. We, of course, boil all of these before they are fed to the hogs, and we have a sanitary and up-to-date piggery which I think it would be a pleasure to anyone to inspect. It is so clean that it is quite proper for the man in charge to do what he has done; he has placed a mat at the front door and a sign "Please Wipe Your Feet." In spite of this, however, we have found that while we were disposing of our garbage we were perhaps encouraging the production of flies, and to overcome this we have determined to put fly screens on our piggery so that this source of danger may be eliminated. But what I am particularly interested in at the present time is to learn some economical method of disposing of every kind of waste, such as waste paper, sweepings, dressings, etc., and perhaps Dr. Clarke or someone else will tell us if there is to his knowledge a method of disposing of this waste whereby the heat produced can be utilized in heating water, and if it is in such a form as to be within the reach, not only of the Toronto General Hospital but of the smaller hospitals throughout the country, such as the one with which I am connected.

Dr. Clarke: Replying to Dr. Dobbie's question I would say that all waste materials are disposed of in this hospital by the large incinerator. We do not keep garbage here at all; we destroy it at once. The cost of our incinerator for this large institution is about $1,650 to install it, but much smaller ones can be procured which would do admirably for smaller institutions.

I must pay a tribute to Dr. Porter for his interesting paper. There were many things about the turtle I did not know before. After all the turtle is not to be despised. Turtle soup has been a sovereign remedy for a great many years, although very few of us can afford to have it.

I do not think I would like to go quite so far as Mr. Porter in relation to the gentleman who had the turtle cure. We did it not because we had unlimited faith in him, but I think the Tuberculosis problem is very important, and we are willing to try almost anything that would give any promise of help, on account of the tremendous number of those suffering from this disease. There are 1,427 cases in Toronto on our list at present. I do not think the hospitals are altogether blind to the problem. I know that last week I wrote a very long report myself on the care and treatment of patients in this Hospital, a report which I hope will bear fruit. The whole thing is a tragedy, and again I have to refer to my good friend, Mr. John Ross Robertson; I am sure what they have done is a wonderful thing. I do not know that Governments are so callous and hard-hearted as you believe. The whole population of this Province and of the Dominion are interested in stamping out this disease and they are simply looking about for the best way of doing it. I am sure as the country moves it will develop the best plan. I do not know which is the best plan, to have large sanitariums or local sanitariums, but I am sure the whole problem will be solved before very long and that the hospitals will do their duty. When this hospital was being thought of people were pessimistic about it; people said money would not be found for the hospital, but money was found, and people are being educated and they will respond splendidly.

THE PRESIDENT: Any further discussion?

A MEMBER: Mr. Chairman, I am interested in a small hospital in the country, of about twenty-five or thirty patients. The Government grant now is to be withheld unless we take in tuberculosis patients, and I understand they are to be isolated. Some patients would be in for a long term and they, of course, would occupy space that has hitherto been used for the acute cases that Dr. Porter has referred to. It is a very serious problem for us, if the Government grant is withheld from a hospital of thirty beds, and Governors, I know, of small hospitals have been adverse to burdening themselves with Tuberculosis. I thought we might get some light on it here as to the views of the Hospital Association in regard to taking in the Tuberculosis cases in the ordinary country hospital.

Dr. Brown: That was just the question I was going to ask Dr. Clarke; what accommodation he is giving the people in Toronto; what methods of segregation he is going to adopt, and so on.

Dr. Clarke: I would very much rather not speak on that subject at the present time because I will have something to say later on.

The President: It seems to me that shacks are solving the problem for a small hospital, at a very small cost.

Mrs. Bowman (Berlin): Mr. President, how are you going to arrange for sanitary conditions in that shack? We have tried shacks, and we still have to take Tuberculosis patients in our public wards, the only place we have for them. If we have an empty ward to spare it can be used, but the shack and the tents are always insanitary; it cannot be put in except at a large expense, and we do not feel like going to that expense.

Dr. Dobbie: It seems perfectly clear from the evidence that the object of the Government in putting them in the hospitals was for the purpose of putting the Tuberculosis situation up to the local community, that when they were compelled to take into their local hospital cases of Tuberculosis, the Tuberculosis problem would become a live issue, and that apparently is what it is becoming. Their object is to stimulate interest in the local community so that each case will be properly disposed if. The only advice I can give is to provide accommodation of a cheap nature, which can be done, including plumbing, for $100 a bed.

Dr. Porter: Not attempt to take them to the general wards?

Dr. Dobbie: Not attempt to take them to the general wards at all.

The President: Any further discussion?

A Member: The Kewance Company has built an incinerator to take care of the material; and there were three others, I cannot remember the names.

Dr. Helen MacMurchy: In regard to the same question, last week I was at a hospital of twenty-five beds. They had been fortunate enough to secure an old stove in which a log of wood of perhaps two-thirds the height of the desk at which the President is sitting could be placed, and the Superintendent said she had no difficulty in burning whatever they had to burn in this stove. She said that the gauze that they used for dressings was always sufficient to begin it.

Mr. Robertson: The reason that you have a large incinerator is, of course, you have to have it to take a mattress. You can get along with a smaller incinerator if you dispose of your mattresses in another way. I know that we had to put one in the Hospital for Sick Children, a large one, because they said if we put in a smaller one we could not use it.

A Member: Sterilized?

Mr. Robertson: Not sterilized; burnt to cinders.

The President: Any further discussion? If not, Dr. Dobbie will make announcements.

(Announcements were made and meeting adjourned at 10.20 p.m.)

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10 a.m., October 21st, 1913.

The President: The first paper on the programme will be by Miss Davidson of the Technical School, Toronto.

Miss Davidson: Mr. Chairman, ladies and gentlemen, I think an explanation will be in order for the reason that I have no paper. The business of the school has been so enormous this last month and I thought the meeting was at the end of the month so I did not prepare a paper, so I thought I would keep you ten minutes in telling you about it. Some nine or ten years ago, some members of the General Hospital Alumni Association came to me and asked me if I could do anything to help the girls who were both in the hospitals and going into the hospitals for training, and the matter was discussed with the faculty of the school and Miss Snyder, Superintendent of the Hospital, and information was obtained from the Johns Hopkins Hospital, Baltimore, with the result that into the

Technical School we introduced the preliminary course such as we have now as far as the equipment would allow along the lines as it was being given in the Johns Hopkins Hospital. In the General Hospital here they have a preliminary course, and I believe in the Minnesota Hospital in Minneapolis. These are the only three hospitals I know of where there is a preliminary course. The members came to me and said the need of cookery was so great that they were handicapped; when an order was given for a particular diet they were very much handicapped; so that the course which we have in the Technical School covers as much as possible, the work is classified as carefully as possible, and the students get from six to seven lessons in cookery in a week for the whole length of time.

At first—to go back to the introduction of the work—it was introduced in the Technical School for a six months term and the fee was twenty dollars. With the increase in the number of students and the multiplication of classes, the overlapping of the six months term caused too much confusion, so we had to reduce the term first to five months and then to four months, and it stays there now. Miss Snyder sent out circulars to applicants wishing to enter the school and told them she would give them the preference if they would take the course, but latterly it was not done. I believe the reason being the girls got afraid to come to the city and pay a fee and their board before entering the Hospital, because the Hospital no longer pays the girls in the training school. I do not think there is any more I can tell you about in the introduction of the work. We have had it in operation now for nine or ten years. There are smaller classes of girls. But I might tell you that a great number of these girls go to American hospitals, and I have had superintendents of hospitals in American cities tell me that they would take as many girls as we turned out from the Technical School. I feel that we ought to keep these girls in our own hospitals, but they have, a number of them, gone to Boston and New York hospitals and also to Western hospitals. We keep track of these girls and in nearly every case they have been a great credit to their hospitals. With very few exceptions they have always been kept. In nearly every case they have been accepted. In some cases she has been unable to stand the work. I spoke to the Association of Superintendents at

Berlin in the spring at the instigation of a superintendent who had had some girls who had received a preliminary course, and I think the idea was at this meeting there would be those in authority over the Superintendents who perhaps could ask for their students to at least consider taking the preliminary course. It certainly gives some aid because the nursing profession is drawn from a great variety of women. Even in the Technical School, in the course, I have had girls who have had four years' University work, two years public school teachers, stenographers, and girls who have gone to a finishing school and then gone home and taken their part in the social life of the community and probably got tired of that sort of thing, and other girls who had left school perhaps at fourteen and went into some industrial work. The fact that the age of admission to the preliminary school is twenty-one or over shows that there is generally a time after they leave school to the time they go into it again. Moreover all these varied types of education mean that the girl is not prepared for hospital work, and so the idea in putting in the preliminary course in the first place was that a common ground would be covered and the Superintendents and others in authority in the hospital would have some common ground to work upon, and for that reason we give them anatomy and physiology—usually there are four periods a week—bacteriology and a lecture and some laboratory work, and I do not know if you are familiar with the fact, we are very much crowded, but we are building a new school and we will have better accommodation for bacteriology. The whole thing is planned to be as medical as possible. Then there is hygiene and household economics, where the girl is taught to scour and to do all the work about the hospital, chemistry, which is designed to meet the needs of the hospital, cookery and diatetics. We have a reference library and in that library the very latest books on such subjects as I have named, and the students are allowed to use these books, to take them home every night. They are not asked to get any special texts unless it is a text on anatomy and physiology, but the very best books of reference are there for their use. If there should be any question anyone would like to ask me, Mr. Chairman, I would be very glad to answer it. (Applause).

AMERICAN HOSPITAL ASSOCIATION

SECTION OF THE SMALLER HOSPITALS.

DISCUSSION ON MR. G. W. OLSON'S PAPER ON HOW TO SUPPORT THE SMALLER HOSPITALS.

(Continued from our last Number.)

DR. NOYES: We have a paid corps of instructors for nurses and the doctor cuts very little figure. A nurse has to nurse for forty or fifty doctors when she is out; I do not see why she should not have forty to fifty doctors to work for while she is in training.

MISS HARTRY: In the hospital from where I came I thought there was just one way of washing hands. Dr. George R. Fowler was chief of staff and he washed his hands, scrubbed them and then he put them in permanganate of potash, then he washed them off with oxalic acid, and then he put on his gloves. Now, I left the Brooklyn Hospital with a firm idea that the only way to wash hands was that way. (Laughter.)

MISS LOUNSBURY: I should like to ask Mr. Olson if he advocates an open hospital for ward service, or for private room service.

CHAIRMAN: Any other question? Mr. Olson will reply to these at the close of the discussion.

DR. FRANKLIN, DALLAS, TEXAS: I have been listening to these discussions with much interest. We have a hospital now about four years old. The first two years we had an open hospital, entirely open and had no staff, and we had a great deal of trouble. Two years ago we organized a staff and still have an open hospital, and we are getting along better. The question, though, has arisen several times whether or not we should continue the open hospital, or have a closed hospital. One of the points brought up to-day, seemingly in favor of the closed hospital, is the fact that you do not have so many young doctors there, butchering up people and killing them. I should like to have an expression here this morning as to the death rate in

the hospitals, closed and open hospitals. I should like to know, because I do not know whether to continue open or closed. I am inclined to believe with the closed hospital you have a smaller death rate.

Miss Jordan: I want to make a plea for the young physician. Most all young physicians who are in our hospital have just finished interneship in larger hospitals and most of them are pretty capable fellows and I should hate to turn them out.

Miss Minnie Goodnow, Boston: I want to answer that last question on the comparative death rate, perhaps it is not fair to answer it on the relative death rate in the open and closed hospital. I have been in two open hospitals and in two closed hospitals, I do not say that they were perhaps average, either one. My death rate was much larger in both of the open hospitals and the results were not nearly so satisfactory. We took anybody and everybody in there practising and the results were accordingly. In regard to my nurses' training, I think my nurses got better training in the closed hospitals. Very true, they have to work for all kinds of doctors when they get out, that is no reason why they should learn all kinds of wrong methods, and they do learn it if you have anybody and everybody practising

Dr. Cook: There was one point made by Dr. Wheeler which I was very glad he made, very glad. We have taken both sides in regard to admitting pay patients and, I cannot state for the cities, but I can state for the towns, and it seems to me we will have this situation: You ask the physicians, if you have a staff, to give their services to the free patients, and there is another point suggests itself, that the public and even lay members, trustees—I find that true in our own case—do not realize that no hospital contributes one minute of medical or surgical service. Not one minute does any hospital, general hospital I am speaking of, give one minute medical or surgical services. They invite the physicians and surgeons to assist in charitable work by giving their services, and the physicians and surgeons accept that invitation, and it is the physicians and surgeons who are furnishing the work and not the hospitals. That wants to be clearly understood.

Now, to come to the subject upon which I am very glad Dr. Wheeler spoke, in regard to the publicly supported hospital not taking pay patients, where would you be left in any small town? You ask the physicians to contribute their services to care for charity patients and yet you say to them you shall not bring pay patients to this hospital, that is the situation as I understand it when you make that rule, and that does not seem to me in smaller places is fair. When you ask physicians to contribute their services for charitable work, it seems to me that they should be allowed to bring their pay patients there.

In regard to open or closed hospital, when we began there were certain members of the board of trustees and we assumed we did not know anything about running hospitals, and our rules tended very strongly towards the open hospital. They were submitted to a large number of hospital superintendents, physicians, nurses and others, and all criticized that point, and so we started our hospital as a closed hospital, because we were advised that that was the best method, because they said, if you let in everybody—I do not know whether it has worked out in those hospitals, but this was what we were told—that if you admit any surgeons to operate, you admit a slovenly surgeon who introduces sepsis in that hospital, it will not be that surgeon or that patient that will suffer, it will be the hospital that will suffer. We are fortunate in this respect, having made an arrangement by which we selected our staff, and they have selected assistant physicians, and we continue that practice to-day, and every physician but one in our town is connected with the hospital, either on the staff or as assistant physician, and that assistant position allows him to bring in his pay patients. In due time he will be promoted to be one of the staff.

Dr. Noyes: I am a doctor myself, and therefore can speak freely on the subject, but I want to challenge one of the statements made. Every doctor who renders free service to the hospital does so for value received. Appointments on hospitals are sought, could be sold at a bonus if that were the practice. There is no credit to any doctor that he gives free service, and he is not generous, I think, in doing so.

that there is a great difference between the management of a hospital out in the Middle West and out here in the East. Out there anyone with fair business ability can easily manage a hospital and manage it without any deficit, but manage it and even make money out of it. Out there, from my experience, hospitals can be run as a good business proposition. Here in the East I fail to see that that can so easily be done. Rates and conditions are so entirely different, and I feel that that is really one thing that should have entered probably a little bit more into our discussion this morning, that we distinguish between what is needed for various sections of the country. The hospital question, as I learned to understand it, is something like the tariff questions. Certain parts of the country want low tariff on certain articles, others again want high tariff; it all depends on where the shoe is going to pinch you. That to a certain extent is true with hospital conditions. What is good and proper in one section is bad in another section. Out West we look upon the hospital as more of a business institution. In the East I am becoming convinced that it is considered more strictly a charity institution, and that it is contrary to the spirit of hospitals to make it in any way mercenary. Which is right, I shall not enter into discussion.

Mr. Henry E. W. Simon, Buffalo: Being a Western man, I, of course, have enjoyed the address of Mr. Olson very much, because Minnesota is my native state, I was born there and came to the East. When our good brother from Brooklyn came up and made the statement that closed hospitals could not be made self-supporting, I wanted to challenge the statement, because I am superintendent of a hospital which is closed and which, up to last year, has been able to pay all its bills. We erected a new building and on the 8th of October moved into it. We have a debt of about $185,000 on that building and that means a very large interest payment. We have in our hospital fifty-nine ward beds. Our charge for wards is $1.25 a day. We have fifty private rooms for which we receive from $2.25 a day to $5.50 a day. Our interest payments are large and they have increased from $900 up to over $9,000 a year. In addition to that we have connected with our institution an Old Folks' Home. That is probably something unusual for a hospital to have an Old Folks' Home connected with it, and we

have fifty-four old people in that Old Folks' Home. That causes a deficiency in our $5,000 a year. We were able to close this fiscal year with a deficiency of less than $1,000. So I think that refutes the statement that closed hospitals do not carry their own expenses. There is one danger, however, in a closed hospital which I have observed and which has caused me considerable concern and a great deal of difficulty and that is this, that if you have a prominent surgeon on your staff who is known to be good and everybody knows that he knows his business, can do good work, there is this danger, that he is going to use his influence in every possible way to have men appointed to the staff who are going to feed him and there is a danger that must be very carefully avoided It means a great deal to a hospital to have a sort of a Czar-like rule from the staff. It means that you are not going to get the support from the public that you should have when you have deficiencies, and I think there is where closed hospitals need to be very careful. I think when you want to raise money the thing that needs to be done is to give due publicity to the work that the institution is doing and then have behind you a good organization which is going to support you in the work that you will undertake. Our institution last spring raised $116,000 in two weeks without very much effort and it was all done without a great deal of publicity. I want to refute the statement that closed hospitals cannot be made self-supporting.

Chairman: There is another paper before luncheon and I think we shall have to close and I will call on Mr. Olson to close the discussion.

Mr. Olson: I put down a few points on which I want to refute the speakers, or corroborate what they have said, affirm it or give a little further enlightenment.

A lady here asked how we do with regard to enforcing the open, or practising the open hospital rule in the wards. Our wards are just as open as private rooms. Because a patient is admitted to a ward is not necessarily an indication that he is poor. We will have patients, farmers who probably own $50,000 in property, can write a cheque for $10,000, who insist on getting a ward bed, because it is better than they are used to at home. There is no reason why we should not permit the doctors

that we admit to the hospital at all to practise just as freely in the wards as in the private rooms. Nobody knows which of our ward beds are free and which are paid. If we have an applicant for the bed in the hospital who cannot afford, who has not the means to pay for his care, he is admitted just the same as any patient who walks up and pays the customary two dollars, and nobody knows whether he is a charity patient. I think it is a mistake to set aside a certain number of beds and say, "These are free beds." It has a bad influence on the nurses and physicians and all that. We do not label our charity patients, and if they require a private room and a hospital nurse, they will get it. Our means of paying for those patients are the means that the good Samaritan found. We find through our association, our Ladies' Auxiliary, or our private benefactors, who probably never want to be known, or request of us to conceal their identity, they pay the expenses and nobody knows which is the charity patient outside of myself or the confidential clerk. We are very careful, however, that the physician who treats that patient does not get any money and if we find any of them doing it he is forever put out of our hospital. There must be co-operation in this work between the hospital and the doctors. The hospital does not make any money on those cases, does not try to, but we want to get out of it, if possible, what it costs to maintain that case, and, as one gentleman said here, the doctors are vying with one another in soliciting or asking for those cases. I have men walk into my office and say, "I have not had a charity case for a long time, you are forgetting me, what is the reason, haven't you got confidence in me?" They are perfectly willing to treat these patients free.

Our hospital is as open as I believe any hospital to be. It is closed only in this respect, that we exercise some discretion as to the admission of physicians. We do not admit any Tom-Dick-or-Harry, who comes along with an M.D. after his name. I have a local medical roster at my receiving desk and we do not admit any man to practise in our hospital who is not a member in good standing of the local society affiliated with the A.M.A. If he is a recent arrival and is not yet transferred, we are careful to find out that he is an A.M.A. physician just the same. I do not believe in a medical trust, but I believe in some safeguards.

Now as to the death rate in open hospitals as compared with the closed, I do not know of any difference, that is, I have not studied statistics. We have had a death rate in our hospital of 3½ per cent., that is, 35 patients per 1,000 admitted. I do not know whether that is high or not, 3½ out of every 100 that were admitted, died in our hospital. Ours has been largely a surgical hospital, doing a great amount of country work, referred to us by doctors in small towns, and in a majority of these cases the people do not come to town unless they are pretty nearly hopeless, so that I think a death rate of 35 out of a thousand is not so very high. Out of 3,024 cases, over 2,700 went through the operating rooms, so I think that with a death rate of only 3½ per 100 we are fairly safe. We have a staff at present of 38. Some are medical, some are surgical, some obstetrical, some eye, ear, nose and throat, and they are assigned each a certain period of weeks or months, everybody being treated alike as nearly as possible. They are called to take care of cases there that are coming to the hospital without having a physician selected beforehand. They are not very many of these cases, but there are people who walk in and say, "I am sick, I want to be taken care of, you have doctors here to take care of me." Well, if that is considered to be a medical case after examination by the chief of the house staff, we call the man who is on duty at that time on medical service; if a surgical case, the man on surgical service is called. If that proves to be a charity case, or very poor, he is not allowed to charge, but in some cases it proves to be a miner or lumberman, or somebody from out of the woods, who comes up and has a roll of a thousand dollars or so in his pocket, we do not begrudge the doctor the little fee he might ask for the attention he gives the patient.

As to the point I made in my paper in regard to hospitals supported by taxation not taking pay patients, I referred to hospitals that are built by bond issues and supported entirely by taxation in order to perform the compulsory charity work which the community feels it is bound to do. In our city we have a city hospital that is bonded to the extent of a million dollars to build that hospital and we are taxing ourselves a great amount each year to support it. I object to such hospi-

tals coming in, taking private ward obstetrical cases in the eleemosynary rooms at less than cost, so that we have to pay taxes to maintain those patients. We have, I might say, as a means of taking care of a good deal of work, a system of looking into cases and finding out where the responsibility is for the patient. We have sometimes poor patients sent in to our hospital because it is known in the West, sent in from North Dakota and other places out West, they simply put them on the train and tell them, "Go to the Swedish Hospital." They come to us, they may have given them the necessary two weeks' deposit to pay down on coming in, but when that period is over we cannot put them out unless they are well. I investigate very carefully and when I found such a condition I go to the county authorities and invariably I get an appropriation from the Poor Fund for the further care of such patient. I just collected a bill the other day of $250 in such a case.

Now the thing to do to make the hospital self-supporting—and we have somewhat digressed in our discussion, from the main question—is to watch every source of revenue. Keep your fingers on it continually and do not let anything escape, because it is no justice to a person who beats you and it is a gross injustice to the people who are helping to support your institution. We have opened a new line of discussion and it is hard for us to keep out of the straight and narrow path. You know we have discussed how to cheapen the food and how to economize in this and that, why not to begin to discuss how to increase our revenue, how to get what it is worth? I have not always been a hospital man; it is less than two years since I took part in another business which ten to fifteen years ago was in the same condition. They were simply vying with each other to cheapen the work and putting a cheap product on the market and one man after another was quitting the business and going back to the farm or raising chickens. Now that business is on a paying basis and they are paying dividends, because they began to study their costs, they began to find out they were not getting any thanks or anything of the sort for distributing their product for less than cost. Nobody is going to thank you for doing that. Why not charge what it is worth? The doctors have solved this question long ago. Where the patient cannot afford to pay a decent fee they do it free.

AMERICAN MEDICAL ASSOCIATION HOSPITAL SECTION

(Continued from our November Number.)

Dr. H. B. Howard, in introducing Dr. H. J. Hall, of Marblehead, stated that Dr. Hall had devoted ten years to the idea which might not be expressed in the paper about to be read. Many people were unfitted for the life occupation they had selected. Such a choice makes the occupation hard and the person breaks down. This subject had been much considered, and the patient was given a new vocation—an occupation which he enjoyed, and life becomes a pleasure. When people have thus become readjusted and they become confident of making a living, they begin to enjoy life and, as a consequence, they procure a new lease of life. Dr. Hall had known of a case—a young man had broken down during his student course—had become a complete wreck. Dr. Hall, after looking him over, concluded that he had the material in him to make a first-class blacksmith; and turned him into a blacksmith. The fellow rapidly improved and when asked how he was getting along, said, "I am not able to think of my own case. If I get to thinking of my case I burn my fingers. So I have to keep on with my work."

Dr. Hall began by saying that it was hard for well people to make a living; how about the sick? In many chronic illnesses remunerative work may be accomplished with physical and moral benefit to the worker. That was the object of workshops in hospitals and asylums for handicapped labor. In Dr. Hall's shops they did not have to search long for the right work for the crippled applicants. Trades were adapted to special limitations. One of the most refreshing activities was in the schools for the feeble-minded at Waverly. An industrial system for patients was ideal. In insane hospitals more and more patients were given work to do in connection with the farms and houses. This was being extended to work-shops in certain places. This activity in charitable and semi-charitable institutions had been very effective. The use of work in sanitaria for persons suffering from nervous exhaustion from over-work or from too much idleness was a recognized therapeutic measure.

These experiments are so hopeful and so beneficial to workers that important developments may result from out-patient workshops. Dr. Hall's experience had been in sanatorium work with the nervously exhausted. The ancient handicrafts offered the most interesting and profitable means of regaining strength. Some modification of these might be valuable for hospital workshops. We might show the therapeutic possibilities of work—the economic possibilities of hospital patients was an interesting thing to consider. The expression craft work was vague. It really was work with the hands instead of by machines. It includes almost any useful and ornamental product from a broom to a coal scuttle. Many articles of daily use were produced in this slow way—the finest work of craft—gold and silversmith, workers in dyes and wools, making fabrics only made by highly-trained workers. There is a slow routine, but a proper routine. Such work can be done by handicapped men who have been thrown out of employment for many reasons. The new system will gather up these sick and discouraged workers, and adapt them to the work, to meet any degree of handicap. One was often surprised in this work. A man or woman injured or worn out often proved highly efficient under conditions slightly altered to meet their special need. The wasteful policies pursued, if continued, some day will make it impossible for society to support the number of sick and idle. Then the new system will come in earnest. The new workshops will have to be subsidiary—the worker is more than the measures. The profits will go to the works. The essayist had been greatly impressed with the grateful loyal labor. It was a contrast to unscrupulousness of the workers, sometimes seen in the regular industries. The new work would be more than a plaything. It must be made worth while and possess a market value.

That was the final test. From a partial experience, the speaker thought that hospital workshops could be made self-supporting. During the last few years he had built up a business in a small way; a great deal of the time it had been self-supporting. It had been conducted as a private venture. The workers had been people of high intelligence, and not in need of self-support. They could not succeed in the ordinary way. The work had been carried on nine years. For a time it was

a financial burden. The work succeeded because expert workmen were employed The work consisted of leather and cement work, pottery, and hand-weaving. Five people in pottery did $6,000 worth of work last year, with one professional. One woman was profoundly neurasthenic. A small group of workers at Gardner, Massachusetts, produced $40,000 worth of supplies on the hospital farm. This would not have materialized without the use of handicapped labor. These patients were physically and mentally better for their experience. They were not overworked. They were pacific cases. A group of convalescent tubercular girls are paying their expenses, $100 at pottery work, while under treatment. Ornamental cement work, brick and tile, were taught the stronger patients, and hand-weaving to the weaker. The hand-weavers would undertake patterns that the power looms could not take. There is a ready market for the hand product.

A central office would be serviceable—to supply materials, designs and formulae, and work out puzzling problems arising about the technical part of the work.

The experiment had pathetic limitations. Many willing to work will not succeed; but a great deal may be accomplished.

Workshops might be established in connection with a few general hospitals, and so it would be ascertained how such employment fits in with the work of the medical and surgical departments. It would prove of great value to the social service workers, who find it difficult to find employment for their charges. Vice and crime breed best in idleness. The plan cannot be worked out by untrained people, no matter how enthusiastic. Expert workers are needed and a business management. The thing can be easily done, and its adoption was recommended to members of the section. The trustees of the Massachusetts General Hospital had authorized the establishment of an industrial department in connection with their outdoor department, on the lines of the workshops at Marblehead.

Dr. E. E. Southard, of Boston, read a paper on "The Psychopathic Hospital Idea."

In America there were three general hospitals with psychopathic pavilions—Ann Arbor, in the hospital of the University of Michigan, established in 1906; Boston Psychopathic, 1912;

and the Phipps Pavilion at the Johns Hopkins University, established 1913.

Others should be mentioned which included nervous as well as mental cases: Pavilion F, in Albany City Hospital. In addition to the therapeutic measures, emphasis was laid upon scientific problems of diagnosis and research. Dr. Adolph Meyer, of New York, had used a certain number of beds at Bellevue for scientific purposes. Besides there was the special study made at Kankakee, Illinois, and at the Neurological Institute, New York City, which latter had taken up in a special way the study of the nervous system and of mental problems. The movement was widening and relating itself to medicine in general, resulting in the establishment of social service schools and schools of philanthropy. Political parties had seized the idea, resulting in the development of local and national committees for mental hygiene, eugenics, study of the feeble-minded. Five years ago a talk on the feeble-minded would be made to an empty hall. To-day the hall would be filled. The discovery of mental tests, the work of Freund, the Wasserman reaction, the discovery of Salversan, have all conspired to bring the mental side of medicine into the foreground, and to make it evident that psychiatry is a branch of internal medicine, and that the general practitioner needs to be a psychiatrist. Our medical schools must pay more attention to psychiatry. It should not be left to the neurologists who have their own special interests.

Instead of having, as one Viennese investigator has termed it, a community of memory—the mental cases being doomed to dementia and death—there is what he has called a community of hope on the part of the physician who feels that something can be accomplished in this field.

The institution in Ann Arbor numbers forty beds.

(To be continued.)

THE AMERICAN HOSPITAL ASSOCIATION

The next meeting takes place at St. Paul, August 25-28, 1914.

The corrected list of members and subjects assigned of the Committee on Hospital Efficiency, Hospital Progress, and Hospital Construction, is as follows:—

Hospital Construction.

Mr. Louis R. Curtis, Supt., St. Luke's Hospital, Chicago, Ill.

Hospital Finances and Cost Accounting.

Dr. R. J. Wilson, Supt., Health Dept. Hospitals, New York, N.Y.

Medical Organization and Medical Education.

Dr. C. K. Clarke, Supt., Toronto General Hospital, Toronto, Ont.

Hospital Efficiency and Progress.

Mr. John Wells, Supt., Latter Day Saints' Hospital, Salt Lake City, Utah.

Hospital Accounting.

Mr. Chas. B. Grimshaw, Supt., Roosevelt Hospital, New York, N.Y., and Mr. F. C. Townsend, Trustee, S. R. Smith Infirmary, Staton Island, N.Y.

Hospital Intelligence

CANADA

The new wings and the nurses' home of the Winnipeg General Hospital, costing $650,000, have been opened. Mr. A. L. Johnson, Secretary-Treasurer, has carried the chief burden of responsibility. The new superintendent is Dr. Sinclair. His predecessor, Dr. Morrill, is practising medicine in Benton Harbor, Mich.

The corner-stone of the new Sainte Justine Hospital, Montreal, has been laid. It is a five-storey building and has accommodation for sixty to seventy babies. It is supported by voluntary contributions. It is under the care of the Sisters of Wisdom.

A new hospital is to be built in Medicine Hat, Canada, to cost $250,000.

The new Jubilee Hospital is being constructed in Victoria, B.C. It will cost $399,840, according to Architect L. P. Rixford. It will accommodate two hundred patients. $200,000 is expected from the city.

Mayor Hocken, of Toronto, has directed that patients whose maintenance is to be met by the city, if emergent cases, must be sent to the General Hospital. The other hospitals are objecting.

A hospital is talked of for the east end of Toronto. The incorporators have applied to the city for a free site on condition of their raising $100,000.

One of the Vancouver aldermen charges that patients suffering serious injuries had been denied admission to the General Hospital until some one appeared to guarantee costs of operations and nursing.

A new civic hospital is being built for Quebec City at Beauport.

A new $50,000 fifty-bed hospital will be built in Walkerville, Ont., and patterned after the St. Catharines General and Marine Hospital. The president is Hiram H. Walker.

UNITED STATES

A Successful Twelve-Day Campaign

St. Joseph Hospital, Yonkers, New York, conducted a twelve-day campaign in October, making the objective $110,000. It is proposed to erect a large additional wing and equip the same. The campaign closed with $122,000 subscribed. Mr. W. A. Bowen, of Waterville, Maine, was the campaign leader. There were over 8,000 subscribers.

This was the third short term campaign conducted in Yonkers within one year, the first being for $125,000 for a Young Women's Christian Association Building; the second one was conducted last June for $125,000 for a Young Men's Christian Association Building, while the hospital campaign followed four months later. All of these campaigns were successful. The results attained in this city of 90,000 people are also notable from the fact that there are two other large hospitals in Yonkers.

Hospital to Cost $250,000

Architect John S. Siebert is preparing working drawings for a four-storey reinforced concrete hospital building to be erected on Cedar street between Seventh and Eighth streets, San Diego, for Alex. T. Crane and J. L. Adams. The cost of the entire structure is estimated at $250,000, and work is to begin in about thirty days.

Hospital Treatment of Patients is Condemned

A report of the city Hospital trustees, prepared by Dr. Henry Spence, concerning the investigation of the recent death of William Mack, a delirium tremens victim, has been submitted to Mayor Fagan. The body of Mack, cut and bruised,

was taken from a cell in the basement of the hospital fifteen minutes after he had been given an injection to quiet his nerves. While the report is to the effect that Mack died from natural causes, it sets forth the following:—

"We feel we cannot condemn too strongly the lack of care shown toward the man in question. From the moment he was placed in the cell in the basement of the hospital he should have been under the eye of an attendant for the purpose mentioned above. That such was not the case was admitted by the hospital attendants. The persons responsible for this condition of affairs should not go unrebuked."

O'Hanlon's Report on Jersey City Hospital

Conditions at the City Hospital have been so bad for some time that an official investigation became necessary and, besides local doctors and officials, who made special investigations, Superintendent George O'Hanlon of Bellevue was employed by the city as an expert to make a general examination.

Dr. O'Hanlon makes a very careful report, in which almost every administrative feature at the hospital is condemned. There is no order or discipline. The out-of-door patients are treated generally, though the clinic is not a certainty and is sometimes left to the internes without regard to their fitness or to the time thus taken from ward work. The nurses' training school is practically useless and the quarters provided for probation nurses are unfit and dangerous as fire traps.

The buildings are not kept clean and there is no discipline among the employés; in fact, there is scarcely anything overlooked in Dr. O'Hanlon's report and all that is mentioned is condemned.

The specific cases which were investigated by others show similar results. In one case investigated by Dr. Spence and others the lack of care shown by the record moves the Committee to advise the censure of those responsible.

The case of a woman patient subject to a drug habit, who was turned out of the hospital, shows the need for a psychopathic ward. She should not have been discharged.

The fact that there was no room for such a case is discounted by Dr. O'Hanlon's statement that the records were so

carelessly kept that some patients had boarded free for several years and that others had remained too long, thus occupying beds which were needed for other patients.

The whole investigation shows carelessness and incompetence and the city officials should lose no time in making a complete reorganization at the hospital. The existing condition is a disgrace to Jersey City.—*The Jersey City Journal.*

Fat in the Fire

A pot of fat was overturned in the kitchen of the German Hospital, New York City, and made such a conflagration that the fire alarm was given and brought out the fire department and tested the efficacy of the hospital fire drill. Superintendent Kortum is to be congratulated on the showing.

Osler on Examinations

Sir William contended that the work of the students from the day they enter the school ought to count for qualification and that the students ought not to be under the continual fear of examination. He said the Chinese system of education, which is directed to a single end, the passing of examinations, shows perfectly the blighting influence of examinations and how they sterilize the imagination.

"The great chasm between education and examination," he continued, "is shown by the statistics of aspirants to the Royal College of Surgeons. Half of the entrants fail, yet these are the very pick of the students. The lectures ought to be reduced. The day of the lecture is past. It ought to be an offence on the part of a senior student to attend a lecture.

"In the case of inefficient students parents ought to be told after a year or two that they will never make decent doctors. There ought to be no written papers at the final examination. Watch the man handle a patient. Fifteen minutes at the bedside is worth three hours at the examination table. The student needs that the incubus of examination should be lifted from his soul. We make the study of our profession an intolerable burden by examinations and the enormous expansion of the subjects of the curriculum."

The address was greeted with loud cheers.

(PUBLISHERS' DEPARTMENT)

" Great Bulk of Oysters Sold are Wholesome

Dr. Carl L. Alsberg, Chief of The Bureau of Chemistry Department of Agriculture, U.S., writes as follows:

"As a general proposition, it is fair to state that people run less risk of contracting typhoid fever from oysters than they do from drinking raw milk, or the water supplied in many communities. The great bulk of the oysters sold are wholesome. The number of oyster beds where pollution is even possible is relatively small. I could wish that the number of dangerous sources of milk supply were as small and that the percentage of pure wholesome milk was as great as the proportion of wholesome, safe oysters that reach our tables."

The purest oysters procurable can be had from the Connecticut Oyster Co., 50 Jarvis Street, Toronto, who have facilities for laying down oysters in Toronto within 36 hours after leaving the oyster bed.

Sanitary Wall and Woodwork

White enamel for interior walls and woodwork of hospitals, sanitariums, public buildings, etc., is conceded to be the most sanitary and suitable coating for the purpose, in that the surface produced by its use is pleasing and durable; while through years of wear very little effort is required to keep it sanitary.

The enamel most widely known and extensively used throughout the world is Satinette, distinguished by the fact that it is easily applied, exceedingly white, and will not turn yellow if applied over a properly prepared surface.

Satinette is made by Pinchin, Johnson & Co., Limited, London, England. It is imported and sold in Canada by the International Varnish Co., Limited, Toronto, who have the exclusive rights and are always pleased to give detailed information pertaining to this immaculate finish.

Elegant Pharmaceuticals

For well on to fifty years, The Palisade Manufacturing Co., of Yonkers, N.Y., have been manufacturing a line of Pharmaceutical preparations second to none. Any bottle bearing the imprint of this firm is at once beyond question, nothing being allowed out of their Laboratories that is not as nearly perfect

as scientific chemists and pharmacy experts can make it. The Palisade list of preparations is, indeed, a lengthy one, but reference each month to the top half of the page opposite editorials in this journal will give Hospital men the most reliable information as to what is best to specify in prescriptions in many puzzling conditions. The Canadian Agent, where sample bottles are cheerfully furnished any time on request by a physician, is Mr. R. L. Gibson, 88 Wellington St. W., Toronto.

Hospital Antitoxins

Hospital authorities will be interested to know of the recent improvements made to the Mulford Laboratories at Glenolden, Pa. These Laboratories are among the finest in the world, no expense having been spared to place them on the soundest scientific foundation. All Mulford Antitoxins, Serums, Bacterins, Vaccines and Tuberculins are prepared under the personal direction of experts. The Laboratories are operated under government license and inspection. Rigid standardization is employed along with the most careful bacteriologic and physiologic tests, thus guaranteeing uniform reliability. Every dose of antitoxin, serum and bacterin is furnished in an aseptic glass syringe with a flexible needle point, positive working piston and finger rests. Hospital Superintendents should remember that the name Mulford stands for everything that is best in Biologic products.

Asepsis in Modern Surgery

In modern surgery, as practised in the great hospitals and institutions, there is no such thing as a trifle, and the surgeon, when in need of Absorbent Cotton, should make sure that the article he uses is absolutely aseptic and free from all impurities. Many so-called Absorbent Cottons now on the market are absolutely unsuited for wound-dressing or other delicate purposes, and prudence should be exercised in the selection of a cotton that is best suited for the proposed operation.

The Maplewood Mills, the largest manufacturers of Absorbent Cotton in the world, make three grades of hospital cotton—"Standard," "Sanitary," and "Absorbon"—that are admirably adapted for hospital requirements.

The special processes by which these cottons are prepared

—comprising over fifty distinct and separate operations—assure absolute purity. A notable feature, not duplicated by any other manufacturer, is the sparkling, crystal-pure water used to prepare these cottons. It flows from the Osborn spring, situated at about a quarter of a mile distance from the Maplewood Mills, in Fall River. Leading analysts and medical authorities have declared that the quality of this water is unexcelled for the purpose which it is used.

As a conscientious practitioner, would you use cotton that has been "purified" with pond or river water, when you can get Absorbent Cotton that is absolutely germ-free at a lower cost than the "ordinary kind"?

An Effective Galactagogue

Lactagol is an interesting substance prepared from cotton seed. It occurs as a pale brown granular powder which is not soluble in water, but swells on boiling. Recent experiments have shown that it promotes the secretion of milk and the quality is at the same time improved. According to our analysis it appears to consist practically entirely of protein substance, the total nitrogen amounting to 15.68 per cent. The mineral matter amounted to 1.51 per cent. and the moisture to 7.08 per cent. The administration of the extract to patients supplying both a deficient amount and quality of milk *led to a decided improvement in both directions. The secretion increased quality and proved to contain richer proportions of fat and albumen.* (Lancet, Sept. 7, 12.)

A Fifty-Years' Reputation

Accuracy as well as durability are characteristics which must surely be present in scientific instruments. The Bausch & Lomb Optical Company, of Rochester, N.Y., have been making special laboratory equipment for over fifty years, which in itself, aside from the reputation they have achieved, is an evidence of the thoroughly satisfactory character of their instruments. They have a catalogue, No. 99A, specially prepared for the assistance of hospital superintendents and physicians in the outfitting of laboratories, containing not only descriptions of the various instruments, but also prices. This will be sent to any reader of THE HOSPITAL WORLD if mention is made of this journal.

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ARE rapidly making history, concerning the all-important question of CLEAN MILK. We build them in various sizes including a small machine for laboratory work by boards of health and others for scientific research. Write us about this wonderful machine, and meanwhile insist on the milk supplied to your hospital, being DE LAVAL CLARIFIED.

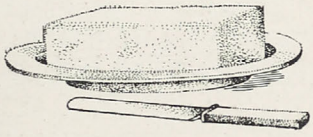
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NEW HOSPITAL APPLIANCES, PHARMACEUTICAL PREPARATIONS, ETC.

A Fine Lot of Sterilized Solutions

Hermetically sealed glass ampoules containing sterilized solutions of important drugs for hypodermic use have assumed a commanding place in medicine in a comparatively short time. Two or three years ago, seeing the tendency in this direction, Parke, Davis & Co. brought out a modest line of something like a half-dozen formulæs, notable among them being solutions of Adrenalin, Codrenin, and Cacodylate of Sodium. From this small beginning the line has expanded until now the company announces a total of about twenty distinct formulæs.

A Large Hospital Supply House

Our readers are referred to page xxxix. of this issue of THE HOSPITAL WORLD, where they will notice the announcement of The Brodeur Co., Limited, who carry an extensive line of goods suitable for Hospitals.

One of the agencies which the Brodeur Co., Ltd., have is that of Berndorf pure solid nickel cooking utensils, manufactured by the Berndorf metal works, Arthur Krupp, of Germany, which cooking utensils are now used all over the world, and are particularly suited for Hospital use.

A specialty with the above firm is the equipment of modern kitchens. The White Star line, after having made the most exhaustive tests of Berndorf nickel, have adopted it for the kitchen utensils of all their latest boats. The kitchen of the SS. "Olympic" are fitted throughout with the firm's cooking utensils, as also were the kitchens of the ill-fated "Titanic." The Berndorf nickel goods will be found also on the Allan line steamships—"Laurentic," "Virginian," "Victorian," and "Corsican."

The Brodeur Co., Ltd., are finding little difficulty in getting the Berndorf nickelware into the kitchens of large institutions. They have introduced it into the leading railway and steamship lines in Canada, including the Canadian Pacific and Grand Trunk railways.

The Brodeur Co., Ltd., have this year secured the agency for Canada of Haviland and Co., hotel china, and among their recent contract for Haviland goods is the "Fort Garry" (G.T.P.) of Winnipeg.

Another of the agencies which the Brodeur Co., Ltd., have is that of Rosenthal china, the highest grade of German china manufactured, a specialty of which china is the under-glaze decoration. The durability of this make of china is unsurpassed, and should be used in hospitals, asylums, and sanatoria.

United Brass and Lead, Limited

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For Doctors, Clinic Lavatories and Hospital Fixtures.

VITREOUS CHINA LAVATORY

Slab, 18 x 25 in. Bowl, 12½ x 20 in.

PRICE, COMPLETE, AS SHOWN - **$40.00**

Invalid Chairs

Hospital superintendents desirous of procuring for their institution invalid, rolling, reclining and carrying chairs should write for a catalogue from The Gendron Manufacturing Co., Limited, Duchess Street, Toronto. This firm make a specialty of these goods and can supply them at all prices, depending upon style and quality of goods used. The Gendron Co. have been manufacturing for a great many years and know the invalid chair business from A to Z. It will pay to get their quotations.

Folding Beds, Trays, Bedside Tables, etc.

For anything in the line of Hospital supplies, from a folding bed tray to the most modern operating table, Hospital purchasing agents should call and see the J. F. Hartz Co., Yonge Street, Toronto. This firm carry a full line of sick-room supplies, all made by the best firms in the United States and England, and their prices are right, consistent with quality.

Fulfils the Standard of Purity

The following certificate from The Institute of Hygiene, Inc., goes to prove that "Robbie Burns" Whisky is a stimulant that will be appreciated by the medical profession. The certificate states:

"This is to Certify that the "Robbie Burns" brand of Scotch Whisky of Messrs R. H. Thomson & Co. of Leith has been passed by the Examining Board of the Incorporated Institute of Hygiene as fulfilling the Standard of Purity and Quality required by them, in evidence of which the Council have affixed the Seal of the Institute hereon."

This liquor can be procured from any first-class liquor store.

Why the Underwood Typewriter Should be in Every Hospital Superintendent's Office.

Because it meets every typewriter requirement, has a wider range of usefulness, does faster work, and gives *better and larger service* than any other typewriter made. Speed, simplicity, convenience, durability, these are distinctive of the Underwood, and the Underwood alone. Ask any one of the thousands of physicians who have used this machine, and he will tell you, without exception, to buy no other. Call and find out that the above statements are but facts. The Head Office is at Nos. 7 and 9 Adelaide Street East, Toronto.

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HYDROX is guaranteed 3 per cent. 10 volumes as the consumer gets it. It is prepared in the most painstaking way by the nitrate barium binoxide process with the highest grade chemicals, and more than meets the demands of the U.S.P. tests.

It is our aim to merit your preference for Hydrox in choosing peroxide of hydrogen—to back each bottle with a guarantee and to back each guarantee with a carefulness of method that will give it the highest meaning to you.

When you consider the new, carefully treated bottles, the integrity of the solution itself, and the convenient sizes (4 oz., 10c—8 oz., 15c—16 oz., 25c.) you will appreciate both the economy and the safety of using Hydrox.

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Messrs. Ingram & Bell, Ltd., Toronto, are desirous of notifying the Hospitals throughout the Dominion that they are Canadian agents for the celebrated Bramhall Deane Sterilizers. These goods are numbered among the finest manufactured, being the result of many years' experience as to what an institution requires in this line. The manufacturers are prepared to satisfy a prospective purchaser that their apparatus will stand any reasonable test, no matter what it is.

Diabetes

The eminent German scientist, Prof. Von Noorden, of Frankfort-on-Main, advocates whiskey to the extent of two or three ounces a day in the treatment of diabetes, and opposes the usual methods of dieting in this disease. Here's where the well-known health-winning qualities of Duffy's Pure Malt Whiskey prove of exceptional value, for, in the treatment of diabetes, as in the many other diseases for which it is famous, the rare purity and exceptional merit of Duffy's as a tonic stimulant place it on the highest pedestal of merit in the treatment of this baffling complaint. Physicians who stolidly conform to the ethics of the profession have publicly recommended and prescribed Duffy's Pure Malt Whiskey as a reliable remedy and preventative for many years, and are inclined to agree with Von Noorden and his school that diabetes is a disease that cannot be treated by general methods.

It is a Marvel

What's in a name? A good deal, if it aptly and correctly describes the thing to which it is applied. Hence the name Marvel for the whirling spray syringe was a particularly happy selection, in fact it was a stroke of genius. Aside from the unique excellence of the article itself, its name is sufficient to sell it. No other syringe stands quite so high in favor as the Marvel. The dilating and flushing effect of the whirling spray of liquid is the specific claim for this syringe, and one which has firmly established it as a hygienic and sanitary necessity.

Hospital Lockers

Is anything more essential for adoption in an Institution? Sanitation nowadays demands that employees be given the use of separate lockers for their clothing, and the same should apply to hospital patients. The only locker that can be sanitary is open and ventilated, manufactured of metal in order to be fireproof. They occupy but little space and each has a separate lock. The Canada Wire and Iron Goods Co. of Hamilton make a specialty of, not only Lockers, but Window Guards, Fly Screen Cloth and Sanitary Steel Tables and Racks.

CHINA, PURE NICKEL, AND GLASS FOR HOSPITAL USE

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Krupp's Pure Nickel Kitchen Cooking Utensils also Nickel Vessels for sterilizing the doctor's instruments. The most hygienic metal for cooking in existence, guaranteed to stand any test—as hard as steel.

Private Ward Outfits for 4, 6, or 12 persons supplied with oak shelves, in stock in Montreal, or can be supplied from works in 90 days.

Haviland China.—Highest grade of Limoges China made. Special thickness for Hospital use. Special designs made to order. Badged in Gold or in same color and design can be supplied in 90 days.

Glassware—Leerdam, Portieux, Belgian, Holland and English glassware carried in stock; Plain or etched. Special designs and Crests to order can be supplied in five months.

FROM STOCK—English White and Gold China, Ridgway's Earthenware Plain white, Red Band or Green Band. Austrian Cut Glass Flower Vases from $2.40 dozen to $9.60 dozen. China Invalid Cups, Flower Pots, Jardinieres and Decorative Pieces.

Cutlery and Silverware.

Pressed Glassware—Heisey's, and other high-class makes.

Rosenthal Hotel China—Speciality, Underglaze Decorations.

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Hospital Equipment

Every visitor to the new Toronto General Hospital has noticed particularly the equipment of beds, ward tables, etc. They are the product of The Hospital Equipment Department of The Murray-Kay, Limited, Toronto—who make a specialty of hospital orders. If the new Toronto General Hospital has been so well served in this line by the firm named, other hospitals will receive equally good service if they address 17 to 31 King St. East, Toronto.

Pure Coffees

The name *Chase and Sanborn* is almost a household word in Coffeedom. It has always stood for everything that is purest in the coffee line. A mere mention of the name should be a sufficient hint to Hospital Purchasing Agents when ordering.

Headquarters for Plating

Hospitals and Physicians should note that The John H. Blake Co., 216 Adelaide Street West, Toronto, make a specialty of repairing, replating, gilding, and refinishing all classes of silverware, spoons, forks, knives, teapots, hollow-handle knives, etc. The firm solicits orders from the Medical Profession and guarantee all work done.

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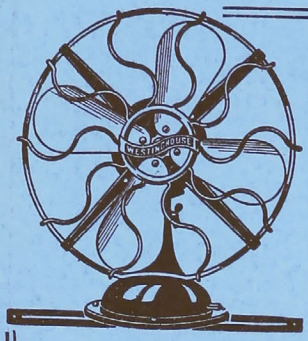
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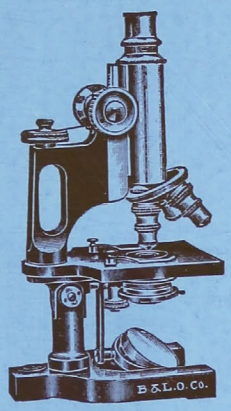
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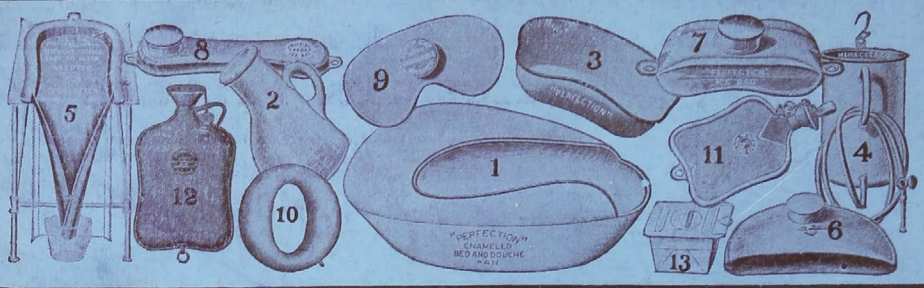
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